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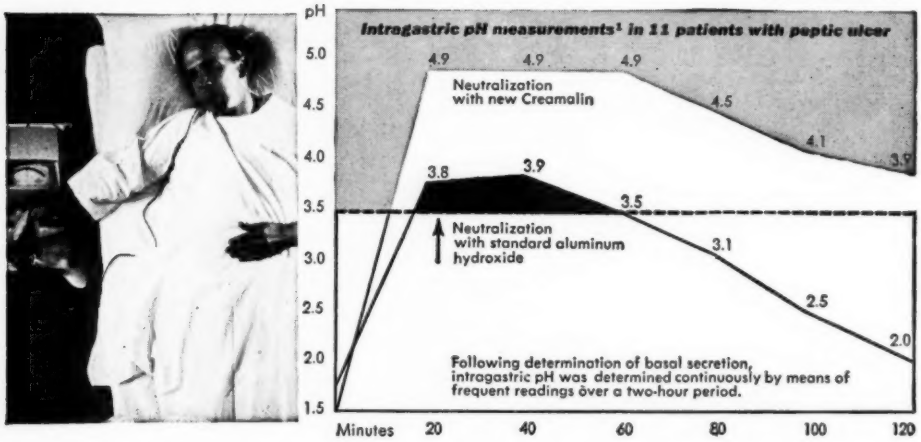

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SEPTEMBER, 1961 — VOL. 57 NO. 9

CONTENTS

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ORIGINAL ARTICLES

A Suggested Medical Association School Health Program—*Donald A. Dukelow, M. D.* 375

Institutional Care of the Unwed Mother: An Analysis of 222 Patients—*Ernest H. Brown, Jr., M. D. and Edward J. Dennis, M. D.* 381

MEDICAL COLLEGE CLINICS

Electrocardiogram of the Month—Quinidine Toxicity—*Dale Groom, M. D.* 386

THE ASSOCIATION

One Hundred and Thirteenth Annual Session South Carolina Medical Association 404

President's Page 388

EDITORIALS

Hot and Bothered 389

Eve Doctors 390

New Oral Therapy for Trichomonas Infections 390

The National Foundation 391

FEATURES

Easter Seal Family Camp 392

Report on Actions of the House of Delegates of the A. M. A. 393

The National Foundation Program 396

Automotive Crash Injury Research in S. C. 396

The Month in Washington 398

Announcements 399

Deaths 400

News 401

Book Reviews 403

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The Journal
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VOLUME 57 September, 1961 NUMBER 9

A SUGGESTED MEDICAL ASSOCIATION SCHOOL HEALTH PROGRAM

DONALD A. DUKELOW, M. D.
Consultant in Health and Fitness
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The consternation that the words "school health" produce in a medical association causes me to wonder. It is interesting how these two simple words when used alone are so clearly understood, but when used together conjure all manner of concept ranging from additional duties that interfere with a physician's private practice to the usurpation of his practice by people employed by the school or the health department. In my 25 years of experience in various phases of public health administration, 12 of which have been on the staff of the American Medical Association, I have yet to see a school health program designed to take from the practicing physician the patients he is so interested in serving. In a few instances I have seen private physicians abdicate their responsibility to the children of the community, so that the health department or the school department had to take over the needed preventive and protective services. But even this is quite unusual.

In my comments today I want to do two things: first, to describe in rather elementary terms a basic program for the protection and promotion of the health of school-age children; and, second, to point up the role of the local medical society and its members who are in private practice as it relates to this program. Since the school health program and the physician in private practice are inseparable, it will be difficult to describe them separately, so you are likely to find some of each in every paragraph.

A paper prepared for delivery before the South Carolina State Conference on Physicians and Schools, March 23, 1961.

A Basic School Health Program

Sometime prior to 1940 the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association and the National Conference for Cooperation in Health Education developed what they called "Suggested School Health Policies." These were originally published about 1940 in both medical and educational journals and as a pamphlet in 1940 and in 1945. The third edition developed in 1956 has been reprinted several times. The first paragraph of the foreword of this document suggests a text for our remarks today:

> "Every school has health policies, written or unwritten, consistent or inconsistent, in or out of tune and touch with the best informed professional opinion. These policies affect the present and future welfare of all school personnel, teachers as well as pupils."

Suggested School Health Policies then recommends six areas for the consideration of those involved with school health:

1. Provisions for Healthful School Living
2. School Health Education
3. School Health Services

4. Supervision of Health Aspects of Physical Education
5. A Health Program for the Handicapped
6. Determination of Qualifications for School Health Personnel

Physicians, both individually and collectively through their medical societies, can legitimately be concerned with each of these six areas. In none of them can either the physician or his medical society carry the sole and entire responsibility.

We are dealing with children of school age. They are minors. In our society the parent has the primary responsibility for the health and welfare of his child. That responsibility may be assumed by a voluntary or a governmental welfare program only when the parent will not or cannot assume that responsibility for himself. So we must consider the parent to be a part of this school health team.

The school, also, has a certain responsibility in relation to them. In this school, we find a group of persons highly trained in child observation, in the growth and development of children, in the emotional adjustments of children, and in the technics of teaching children and helping them to learn. These educators have an immediate interest in the health of the child. They may suspect, through their daily contact, health needs that could be overlooked by the physician who sees the child only occasionally or who may see him only during some acute illness which overshadows a developmental problem, an emotional problem or some other handicapping situation that is not readily obvious. These teachers also carry the burden of health education and physical education. It is obvious that they, too, must be a part of this health team, because they certainly have a fundamental interest in the health protection of the child.

When these children are not in school they are in the community, and are having contacts with all manner of community facilities and personnel ranging from their peers to the adults who serve them, and to their parents who provide them with the necessities of life. In this community we find all manner of agencies, both voluntary and governmental, which in some way touch upon all or part of this group. For example, the health department serves all of them all the time and, in special circumstances, may have a peculiar responsibility which no other agency may bear. Some are clients of a welfare department. Others may be benefited by a crippled children's program, a mental health program or some other variety of community activity. It is not too remote to consider the influence on their lives of the sound teeth that result from the fluoridation of the community water supply, or in communities where it is needed, the universal use of iodized table salt, or the protection they receive from community-wide insect control, particularly mosquito abatement.

In the school are a number of adults. Some are on the faculty, some in administration, some conduct custodial services or serve as bus drivers, technologists, or in other specialized responsibility. The physical and emotional health of these adults is important, not only to the health and well-being of the children but to these adults themselves and to the families in which they live and to the community in which they serve.

In all of these situations, it is rather obvious that the medical association and the physician have a specific relationship to school-age children and the school in which they attain their education and spend half of their waking hours during half of the days in their year.

Medical Society Responsibilities

You are going to say at this point, "Yes, this seems very logical, very reasonable, but how does the busy private practitioner fit into this picture? What can the medical society do as a group? How do we keep the health department or the school from usurping the prerogatives of the private physician?"

I doubt very much if either the school or the health department wants to usurp the private physician's responsibility. If the practicing physician had a clearer concept of his role in community health he would be less fearful. Helping him understand that role is his medical society's responsibility. Probably those best informed about the physician's role in school health activities are the members of the school health committee of the state medical society and of the medical societies in the larger population centers. They should see that the phy-

sicians within their area of jurisdiction become informed about some of the trends in the school health program.

Individual Physician's Problems

First let's consider a few of the responsibilities of individual physicians. One of the great bones of contention is the immunization program. Whenever a health department administers a vaccination, a DPT shot or a dose of polio vaccine some physician in private practice becomes excited about the health department "taking over." In most of your communities the private physician has been given every opportunity to immunize the children and even the adults within his practice. It is only to carry out the health department's responsibility of maintaining a herd immunity adequate to the prevention of disease outbreaks that causes them to step in and fill the gap with immunization when unimmunized persons are found in the community. Physicians might help their school patients maintain a reasonable level of immunity against those conditions for which immunization is accepted practice, and then help plan community programs that will give this same protection to those who are not nominally the patients of private physicians.

Another example of a misunderstood practice is the so-called health examination or health appraisal. These are not synonymous. Health appraisal is a series of activities culminating in the medical examination and expression of judgment by the physician, with follow-up for care, if needed. Appraisal begins with teacher observation, with weighing and measuring, with screening of visual acuity and the testing of hearing by an audiometer. All of these bits of information noted on the school health record are ultimately transmitted to the physician who will do the examination. They give him information he could get in no other way. Ideally from both the medical and the education point of view, the medical portion of health appraisal should be performed by the child's own physician in his own office, with the school's records before him. When the doctor reports to the school, he should give the school some idea of the problems facing the child and the ways in which school personnel can help the physician insure the maintenance of proper treatment, necessary restrictions, and the general supervision that leads to recovery. It is not necessary to give the school all of the detailed information used in arriving at a diagnosis. If it should happen that the child has no personal physician, it may be necessary for the school physician or medical advisor, or the health officer acting in that capacity, to make the examination and, on the basis of his recommendation, refer that child to a practicing physician or to a welfare department for needed therapy. How this works out in any community must be locally determined by the medical society, the health department, the school department and the welfare department in ways that meet the needs of the children and the customs of practice in that community.

A third illustration of interprofessional irritation is the so-called "excuse from gym." Physical education teachers become very irritated, and rightly so, with the physician who writes a blanket excuse for some apparently normal child that allows that child to escape physical education activities and the inevitable showering that follows. Though some of these excuses are legitimate, the physician has been pressured into writing most of them at the request of an over-protective parent or the parent of a girl who does not want to undo a carefully prepared hairdo by subjecting it to the damping effect of a shower. He is giving a medical excuse for a social situation. Where physicians and physical educators develop an understanding of the excuse problem the physical educator will usually be able to fulfill the physician's request for a specific degree of exercise or inactivity, or special exercises according to the needs of children who have problems. Interprofessional understanding leads to a mutual respect that avoids the blanket excuse for gym. This permits the physician to prescribe a very temporary relief from overactivity while a child is recovering from an acute illness, to be specific about the limited activity for those with a rheumatic heart or some other reason for limited activity, or even permits an occasional child to have bed rest in the health room during the time other children are physically active in the gymnasium. These types

of modified physical education are effective only when worked out in terms of mutual understanding among people who must deal with the same individual, the school child, who is of concern to all of them.

Medical Association Problems

In preparation for our National Conferences on Physicians and Schools, state medical associations are asked to report on the membership of their school health committees and on the school health activities that are carried out by the medical societies through its school health committee or some other committee related to school health. The variety of the response indicates a considerable ingenuity on the part of physicians in helping to promote the health of children in the schools. Without identifying the states involved I would like to suggest to you things that have been done by others with the hope that some of these may be possible activities for your committee and can be carried out in South Carolina.

Innumerable states conduct conferences such as we are having today, a few on an annual basis, most of them on a once in a while basis. One state has had nine state conferences since 1947. Some state medical associations collaborate with the large community medical socities within their state to develop regional conferences which serve a group of related counties with similar problems. A larger group of physicians can benefit from this because the shorter distances involved will permit many more who are busy to participate. A few county medical societies have had their own local Physicians and Schools Conferences contained entirely within their own community using their own resources and depending largely on local people for their program.

A number of medical societies report coordinating committees. Though the medical association does not "run" the coordinating committee's program, it often is instrumental in initiating this program. The coordinating committee, as a rule, includes the department of health, the department of education, the medical association, the dental association, the more prominent voluntary health agencies that are concerned with the health of school-age children, possibly the association of school administrators and occasionally the welfare department. This can be done at the local level as well as at the state level, and has somewhat the earmarks of a school health council.

In one state every county medical society in the state appointed a man or a committee on school health. These individuals or committees function as medical advisors. It has been suggested to them that they form an interprofessional advisory committee similar to the one at the state level. One medical society has used *Suggested School Health Policies* as a guide to develop a workable set of policies. They are also defining the job of the school physician and his relationship to the private physician. Incidentally, this relationship was quite well defined in the report of the Second National Conference on Physicians and Schools in 1949 and the American School Health Association, through a committee of which I am chairman, has just published one report on school physician responsibilities in the *Journal of School Health* and another study on school physicians is in process. These might be helpful to you.

Medical societies of many states cooperate with the university and with departments of health and departments of education in the conduct of health education workshops during the summer. I have personally attended a number of these workshops and encountered one pattern which I would strongly recommend to you. Often workshops for teachers and school health personnel are conducted for university credit over periods of several days. In two states that I know of, the last day of this workshop was devoted to physicians. In the morning the physicians meet with the teachers on problems of common interest. In the afternoon the physicians, under physician leadership, discuss some of the health problems encountered in the school health program which are peculiar to their interests. These were not the clinical problems of medicine, but were the administrative problems of trying to coordinate medicine and education, the physician and the teacher, into an effective team. The terminal banquet was enjoyed by all. This idea of a "clinical pathological conference" on the administrative problems of school health I have found to be very helpful

and could well be a part of a school health conference sponsored by physicians. It helps settle the relative responsibilities among representatives of varying professions such as the physician, the dentist, the nurse, the psychologist, the audiometric technologist, the classroom teacher, the school administrator, the physical educator, and any others which might by chance come into the picture.

Several medical associations that publish journals have two or three articles regarding school health each year. The principal papers from a meeting such as this or papers on school health prepared by the committee or physicians in the school or health department who have first-hand knowledge of school health practice would be suitable.

At least one medical association is encouraging its local medical society to take the time to instruct teachers in how to observe children. Teacher observation is an important part of the screening program in the school health program and if teachers know what to look for and what behavior patterns or appearances are significant they are much more likely to refer these children through the family for medical supervision. Help on this can be obtained from the book, "School Health Services," published by the Joint Committee on Health Problems in Education; from their pamphlet on "Health Appraisal of School Children," and also from the writings of Dr. George Wheatley of the Metropolitan Life Insurance Company, who is the current president of the American Academy of Pediatrics.

One problem which often causes interprofessional misunderstanding is the pattern of referral. Medical societies working with the local school administration and the local health and welfare departments can work out a standard pattern for referral that fits their community so that the child gets to appropriate medical attention and the parents' prerogative is protected.

The patterns for conduct of screening programs and the standards to be used as the basis for referral are commonly agreed upon by a joint meeting of medical and education personnel. This is particularly important in regard to screening procedures for vision and hearing. In a rural state, where the services of an ophthalmologist or otologist may not be readily available, it is sometimes difficult to know which physicians are equipped to perform the further studies required for the prescription of a hearing aid, or to know who are trained in refraction so that they may help children with visual problems. Only when this kind of a situation is resolved at the local level in an equitable and accepted way will it be possible to give all of the children the help that they may need.

Since injuries and sudden illness occur at the school, the medical society should work with the school administration to design mutually acceptable "standing orders" and patterns for their administration. School people should know what physician should be called for each child in case the parents are not available to assume their own responsibility for their own child. In some critical emergencies, one may not be able to wait for parents' permission or selection of a physician and a physician must be called as a lifesaving measure. In any instance, all teachers should have first aid training, or at least those engaged in the hazardous areas of the school, such as playground activities, the gymnasium, the sports program, the home economics department, the shops, the laboratories, etc. What is expected by physicians of teachers performing first aid, what parents should expect of teachers in the way of notification of injury or illness, and the manner in which physicians are called for emergency care should all be worked out in advance and agreed upon so that there is no question at the time of an emergency.

Closely related to this emergency situation is the problem associated with physical education and athletics. It is not unusual for children to be injured in contact sports. There should be a definite understanding between the physicians of a community, the schools, and the parents of the participating players about who should do what under any given set of circumstances. Also, there should be a definite understanding about the physician's responsibility for deciding when an injured player may return to play. This should not be left to the judgment of the coach or trainer whose primary interest occasionally is in win-

ning, even though he may have some interest in his players.

At least one state medical association supplies the school health committee of the county medical societies within the state with publications on school health, including those coming from the American Medical Association, from the Joint Committee on Health Problems in Education, and from a number of other sources as well as those which are published by the state medical association itself. This gives the school health committee the most recent information and supports them in their deliberations with education personnel.

Conferences on athletic injuries, symposia on sports medicine and clinics for coaches and trainers are becoming increasingly popular. These programs sponsored by medical societies promote the relationship between physicians and those responsible for the safety of children in the sports program.

The increasing demand for the teaching of mathematics and physical science has caused some schools to neglect or discontinue health education and physical education. A project of several medical societies is to impress on school administrators, curriculum coordinators and boards of education the vital need for education in healthful living and to use the resolutions on health and physical education of the A.M.A. House of Delegates as evidence of medical interest in these areas. In one state this is done by medical society sponsorship of a school health conference for school administrators, in which the two groups can discuss their common interests at the professional level.

In cooperation with the Academies of Pediatrics and General Practice a few medical societies cooperatively established suggested minimum standards to guide physicians in the medical examination and supervision of school children, including standard report forms.

Adult health education to promote better understanding of the needed health and medical services for school-age children among parents, teachers and the professions is the project of one medical association. This is directed at the health program in private and church schools as well as in public schools.

This has been a rather rambling and disconnected series of examples and illustrations. Nevertheless, I have tried to give you a point of view. Medical associations, both at state and local level, have an obligation to keep their physicians informed on what is good school health practice. At the local level, medical societies and physician groups in communities within the area of their jurisdiction should be constantly in touch with the education personnel of the community and working with them in the interest of children. Only in this way can effective school health programs be conducted.

Substitute ileal ureter in an infant with congenital hydronephrosis of the left kidney and congenital cystic hypoplasia of the right kidney. By K. M. Lynch, Jr. & R. R. Bradham (Charleston) Surgery 49:278, Feb. 1961.

The case of a child born with congenital cystic hypoplasia of the right kidney and ureter and congenital hydronephrosis of the left kidney is presented. Salvage of the markedly impaired left kidney was accomplished by substitution of an ileal segment for the stenotic left ureter. The case and technique of the operation are discussed in detail. This procedure, by eliminating the nephrostomy tube in the left kidney and adding the protective mechanism of peristalsis to eliminate stasis in the renal pelvis, should give maximum protection to the markedly impaired kidney. The future of this child is dependent on avoidance of any renal insult by infection or dehydration. It is the authors' belief that replacement of the ureter with a segment of ileum is a sound procedure and should find application in cases in which a functioning kidney is present but compromised by an inadequately functioning ureter.

Practical experiences with therapy of barbituric acid poisoning—J. Knichel. Muenchen Med Wschr—103:307 (Feb. 10) 1961.

In the last few years 225 patients with barbituric acid poisoning were treated by combined therapy which included careful nursing, exact control of autonomic functions, intensive measures against anoxia, shock, and infection, and extensive administration of antibiotics, strophantin, norepinephrine, cortisone derivatives, and methyl-ethyl-glutaric acid-imid (Eukraton). The mortality rate with this combined therapy was less than 1% and was, therefore, strikingly lower than that with all other methods of treatment reported up till now.

INSTITUTIONAL CARE OF THE UNWED MOTHER

AN ANALYSIS OF 222 PATIENTS

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The young mother with an illegitimate pregnancy poses an increasing problem in our present society. Institutions that provide adequate prenatal care and an organized program for rehabilitation are in great demand.

The following study was carried out in such an institution in order to determine first, the presence of any problems peculiar to the management of these patients and second, to observe a controlled group of young pregnant women under currently accepted methods of prenatal care and delivery.

Material

During the period from July 1957 to July 1959, 222 mothers were admitted and delivered of 224 infants. The duration of pregnancy at the time of admission averaged 22 weeks. Patients were admitted from most of the states along the eastern seaboard with the vast majority from South Carolina and North Carolina.

A complete prenatal examination by the referring physician was required before the patient was accepted. Standard laboratory examinations such as serum tests, Rh factor, blood type, etc., were performed and any deficiencies were corrected shortly after admission. A chest x-ray film was deemed essential in view of the close association of the patients during their stay.

Prenatal Care

It is necessary that all personnel involved in the operation of an institution of this sort establish certain, dedicated principles and philosophies, and that there be unanimity in acceptance and enforcement of these aims.

The administration of this institution was achieved through a board of directors selected from outstanding civic minded women in the community. In direct charge of the patients and the minute details of operation is the executive director selected by the Board. This individual determines the efficiency and success achieved by the institution.

Meticulous detail in insuring anonymity offered, at least initially, the most attractive inducement toward admission. This can be maintained in almost every instance even when the patient is admitted to a relatively large hospital. Selection of medical personnel, including medical students and student nurses, from a geographic origin remote to that of the patient was effectively accomplished, in this series.

The presence of a practicing obstetrician, as well as a resident at the weekly clinic and in selected instances in the hospital, created an added prestige and importance to the operation in the eyes of the dubious patient. Needless to say, it was excellent training for all involved.

An appeal for discipline and conformity to established doctrines of prenatal care could not be achieved by the emotional approach in this group. Rather, it had to be based on an expressed and explicit reasoning basis that was comprehended by staff and patient.

Spiritual needs could not be underestimated, and fundamental religious freedoms were not altered or revoked in any manner. A readily accessible place of worship as well as an intelligent specialized approach to instruction comprised an integral function in operational success.

Nursing staff was selected on the basis of proficiency in the profession as well as a sincere interest in the total patient problem. Around-the-clock coverage by nurses in ap-

Presented at Bal Harbour, Florida, Oct. 29-31, 1959, District IV, The American College of Obstetricians and Gynecologists, Annual Meeting.
Supported in part by a grant from Wyeth Laboratories, Philadelphia 1, Pennsylvania.

propriate shifts provided a security of unquestionable importance to the patients. Those who, out of curiosity, delve into the origin of the patient's dilemma can quickly destroy the effectiveness of the institution, and should be replaced.

Careful selection of patients was impossible in most instances. This problem was resolved by quickly removing any patient who consistently interrupted the harmonious atmosphere of the other patients. An attempt to limit admission exclusively to the primagravidas would be inaccurate and unfair. Many deserving multigravidas would thereby be refused admission purely on a categorical basis, and many alleged primagravidas are actually multigravidas with well preserved-reproductive system appearance.

A carefully supervised program of baby sitting by the patients in selected homes allowed them the opportunity to observe a well integrated family group in operation. Many of them never knew such an institution existed.

Allocation of certain responsibilities of house-keeping on the basis of individual adaptability was essential to operation and important in eliminating idleness. Any attempt to do this on a basis of having the patient work for her keep was discouraged.

The presentation and demonstration of a proved and successful plan of prenatal care and delivery shortly after admission is most important. An avowed sincere interest on an individual basis of the total problem is equally important. The maintenance of a relaxed but organized atmosphere of individual cooperation served to promote and maintain discipline and efficiency. A plan of operation prepared under the direction of representatives from different fields eliminated some of the bias and projection characteristic of the human mind.

A Board consisting of an internist, psychiatrist, psychologist, registered nurse, dental surgeon, clergyman, social worker, accountant, hospital administrator, and obstetrician is of inestimable value in improving the scope and effectiveness of inpatient care as well as in follow-up, the latter being one of the most neglected phases of this type of program.

General Considerations

Careful attention to nutritional requirements is achieved through the efforts of a full time dietician. Particular attention is given to increasing the protein intake to 50 per cent over the ordinary requirements. Salt restriction is maintained in all patients and in those showing excess weight gain, rigid enforcement is provided by a separate diet table.

Vitamin supplements are available at each meal and ferrous gluconate is used to provide adequate amounts of iron.

Antenatal Complications

Toxemia of pregnancy, diagnosed according to standards adopted by the American Committee on Maternal Health in 1952, occurred in 3.6 per cent of the patients.

One of the patients classified as toxemia was a woman with known hypertensive disease of 16 years duration.

Average weight gain during the third trimester was 7.5 lbs. Total weight gain averaged 17.9 lbs. with variations from a loss of 16 lbs. to a gain of 43 lbs.

Diabetes, rheumatic heart disease, congenital heart disease, and other significant complications of pregnancy did not occur often enough to justify comment.

Oral diuretics were used freely and bed rest in the home was utilized for those demonstrating a lack of response to salt restriction and diuretics.

Labor and Delivery

Of 222 patients delivered, 175 were primagravidas and the others multigravidas of variable parity (Table I). A duration of labor of 12.4 hours in the primagravidas and 7.9 hours in the multigravidas in our series is accurate since the onset of labor was observed by professional personnel.

Table I
AGE AND GRAVIDITY

Gravidity	Age 13-15	16-20	21-25	26-30	31 & Above	Totals
1	14	103	38	15	5	175
2	0	13	16	0	5	34
3	0	1	4	3	2	10
4	0	0	0	1	1	2
5	0	0	0	0	1	1
					Total	222

Premature rupture of the fetal membranes occurred in 9 patients. When this occurred, the patient was immediately transferred to the hospital for sterile vaginal examination to rule out abnormal presentation or prolapse of the umbilical cord. All patients with these complications were delivered within 48 hours except one who delivered 6 days following rupture. Six of the 9 patients delivered premature infants.[6]

Our plan of premedication involved the use of meperidine and promethazine* administered intramuscularly, in varying doses. After a period of trial, 50 mg. (1 ml.) of meperidine combined with 50 mg. of promethazine was found to be the most effective in achieving adequate analgesia with the minimal depression to the infant.[5, 6] In the labor room and before transfer to the delivery rooms, trichloroethylene was offered to all patients to use if they desired.

Nitrous oxide and oxygen were used as the anesthetic agent for delivery in 188 patients. Cyclopropane was used as a supplement on 16 occasions. Saddleblock was utilized in 31 patients and continuous caudal anesthesia in 3 instances. Pudendal block with 1 per cent xylocaine was used in most instances with inhalation anesthesia.

Low forceps is our preferred method for delivery and was used in 149 deliveries (table II). On three occasions rotation for transverse arrest had to be done.

Midline episiotomies were used on 178 occasions with third degree extension occurring in 51, an extension rate of 28.6 per cent. Mediolateral episiotomy is preferred in large babies, small perineal bodies, or breech.

There were 3 cesarean sections performed, an incidence of 1.4 per cent. The indications for section were one previous section, another in a primagravida in early labor with a breech presentation and a compromise pelvis, and, another in a primagravida with uterine inertia, fetal distress, and a contracted pelvis.

Uterine inertia was encountered in 10 patients, 4 of whom should be classified as having secondary inertia. Dilute intravenous pitocin was effective in achieving delivery in all but one case, and was contraindicated here because of a contracted pelvis. Abruptio placentae was found in 2 occasions and in both instances was found on examination of the placenta following an uncomplicated delivery.

*Promethazine hydrochloride and meperidine hydrochloride available as Mepergan® from Wyeth Laboratories.

Infants

There were 224 infants delivered including two sets of dizygotic twins. Prematurity was a complication on 21 occasions as was one immature delivery. There were 2 stillbirths and 3 neonatal deaths.

One stillborn was an immature infant delivered by pitocin induction following death of the fetus in utero in a 25 year old primagravida with juvenile diabetes. The other stillbirth occurred in a primagravida at term with breech presentation, prolapse of the umbilical cord following spontaneous rupture of the membranes, and death of the fetus before cesarean section could be performed.

Table II
TYPE OF DELIVERY

Spontaneous	41
Low Forceps	149
Mid Forceps	16
High Forceps	0
Breech	15
Cesarean Sections	3
Episiotomies	
Midline	178
Third degree extensions	51
Mediolateral	28
None	16

One of the neonatal deaths was an assisted breech delivery of a 3 lb., 1 oz. infant in poor condition at birth who succumbed 12 hours following delivery. Another was a 3 lb., 3 oz. infant delivered as a second twin by low forceps, with death due to hyaline membrane disease 48 hours following delivery. The third neonatal death occurred in a 6 lb., 1 oz. infant with multiple congenital anomalies incompatible with life.

Since this study was also planned to evaluate dosage and administration of analgesics during labor, careful attention was paid to determination of the breathing and crying times. Within one minute after delivery 216 of the infants either breathed or cried. Five of the infants breathed within four minutes and, on 3 occasions, the time was greater than 4 minutes.

Postpartum Complications

Puerperal endometritis occurred in 5 patients before discharge from the hospital, the average hospital stay being 3 days (table III).

Mastitis occurred in 2 patients and infections of the urinary tract in 5.

Bladder atony of a mild degree was a complication in 15 patients, 10 of these experiencing minor and 5 major difficulty.

Significant infection of an episiotomy occurred in one instance during hospitalization and this in a midline episiotomy without extension.

Table III
COMPLICATIONS

Pre-eclampsia		7
Hypertensive vascular disease		1
Uterine inertia		10
Premature rupture of membranes		9
Abruptio placentae		2
Pyelonephritis		2
Cystitis		3
Mastitis		2
Puerperal endometritis		10
Bladder atony	Mild	10
	Severe	5
	Total	61

Discussion

The problems of indoctrinating these young mothers in a home for prenatal care and delivery are nonexistant when approached with an attitude of sincere kindness and understanding. Every effort is made to create a real sense of security since it is this trait that is notably absent in this group. As condemnation of the illegitimate pregnancy has been more than adequately performed by society, our goal is to relieve as much as possible the agony perpetuated by the ever present intrauterine life continually reasserting its presence and with it the stigma of its existence.

Education of the patient in preparation for labor and delivery has received considerable attention both in the lay and medical press. A simple yet satisfactory philosophy would seem to be a transfer of confidence and security to her medical or professional attendants during the time of labor and delivery. This has been achieved in this group through a feeling of friendship and mutual understanding engendered by frequent clinic visits and attention to even the most minor complaints. A most effective means of preparation has been free discussion, both among the prepartum girls themselves, and also with those who return to the home for 2 weeks postpartum care prior to discharge.

The significantly lowered requirements of analgesic drugs in this series seems to illustrate two important points. First, adequate psychological preparation of a patient for labor decreases the need for the administration of large doses of drugs, and second, desired levels of sedation may be achieved by using compounds with proven synergistic effect thereby reducing the need for drugs known to depress the infant.

Promethazine was selected because of the notable infrequency of side effects associated with its administration over a broad area of experience. Initially, a dosage of promethazine 25 mg. and meperidine 25 mg. was used but this did not produce the desired levels of sedation. Increasing the dosage of promethazine and meperidine to 50 mg. each achieved satisfactory sedation without an appreciable change in effect on the infant.

After establishing what we found to be the optimum dosage, incorporation of the two drugs in a solution prepared in disposable sterile needle unit form* was made available for study. This proved superior since it facilitated administration as well as reducing total volume required.

The midline episiotomy was selected for use in order to confirm our impression that it produced less postpartum discomfort than other types.[1] We also believe that when properly repaired, detection of the episiotomy scar in later years is less likely to occur. This is understandably of great concern to the patient who we feel should be allowed the prerogative of divulging her past history. As noted, extension of the incision into the rectum denotes no increase in postpartum complications, and restricted diet, laxatives, and antibiotics are not required.

A cesarean section incidence of 1.4 per cent may seem somewhat low in view of the predominance of primagravidas in the group. However, a critical review showed no instances in which abdominal delivery should have been performed. Such an analysis is

*Mepergan Tubex, Wyeth Laboratories.

necessary to insure the fact that exaggerated conservatism does not exist as a result of conscious or subconscious effort to utilize cesarean section only as a last resort, since limitation of reproductivity as well as an abdominal scar would effect greater emotional trauma to these young mothers.

The 3.6 per cent incidence of toxemia in this group is reassuring in the sense that it reflects a definite decrease over the average in our geographic location. However, it is disturbing in the realization that it may well represent an irreducible minimum.[1, 4, 5, 7, 9]

It is important to note that even with an incidence of toxemia approaching 4 per cent, induction of labor because of increasing severity of the syndrome was indicated in only 2 patients.

Of equal significance is the notable absence of toxemia contributing to intra-uterine or perinatal fetal death.[2] Thus it would appear that careful control of early manifestations of the toxemic syndrome will in itself eliminate certain inherent dangers to the fetus and prevent the relative emergency created by increasing severity of the signs and symptoms in forcing delivery of the patient.

Acetazolamide and chlorothiazide were used frequently in correcting fluid retention and were found effective in most instances. Some patients receiving chlorothiazide with restricted sodium intake complained of subjective symptoms suggestive of hyponatremia, and this was corrected by allowing a regular diet while on the drug.

This group emphasized the importance and value of bedrest in treating excess weight gain due to sodium and water retention. If an ambulatory patient on diuretics did not lose weight rapidly, she was put at bedrest for 48 hours and almost without exception showed a satisfactory response.

Summary

1. The unwed mother must have a place providing security, seclusion, understanding, and superior obstetrical care supported by the society which has to accept the responsibility for her dilemma.

2. Careful selection of analgesic drugs reduces the requirements of those known to depress the infant. Since our knowledge of the hazards created by decreased oxygenation to the infant is incomplete, our efforts must be directed toward prescribing the minimum amount necessary to provide comfort to the mother.

3. While toxemia may not be completely preventable, the maternal morbidity and fetal mortality can be reduced by following firmly established basic principles.

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MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Quinidine Toxicity

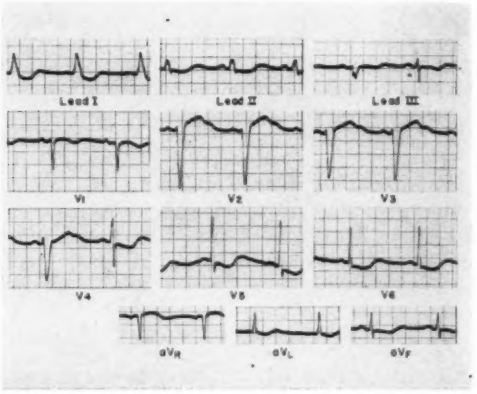
DALE GROOM, M. D.
Department of Medicine

Case Record—A sixty-five year old lady was admitted to the hospital because of atrial fibrillation with a rapid ventricular rate and mild congestive failure. Its onset had been paroxysmal over the previous few months, the attacks often awakening her from sleep with orthopnea, weakness and a sensation of "fluttering" in the chest. Of note in her past history was treatment of hypothyroidism and, some two or three years prior to the onset of her cardiac arrhythmia, the onset of claudication and of typical angina pectoris.

Significant findings at the time of admission were a rapid and grossly irregular pulse, moderate obesity, occlusive arterial disease of both lower extremities, hypercholesterolemia and evidence of pulmonary congestion on auscultation and on the chest roentgenogram.

Because her atrial fibrillation was known to be of recent onset, a concerted attempt was made to restore a normal sinus rhythm. After digitalization which reduced the ventricular rate below 100, quinidine sulphate was given orally on a schedule of 200 mgm. every 2 hours for five doses without any symptoms of toxicity or change in the cardiac rhythm. The dosage was therefore increased on successive days to 300 mgm., then 400 mgm. every 2 hours when her pulse abruptly became regular and this electrocardiogram was recorded.

At this point the quinidine was decreased to a schedule of 300 mgm. every 4 hours day and night, adequate to maintain the regular sinus rhythm. Next day, however, the patient suddenly ceased to breathe, became pulseless, cyanotic and unresponsive. Almost immediately artificial respiration and external cardiac massage by rhythmic pressure on the sternum were begun and within a few minutes the patient was resuscitated. An electrocardiogram then showed atrial fibrillation with intermittent left bundle branch block, both of which persisted in all subsequent tracings. No further attempt was made to restore a sinus rhythm. The patient's recovery from this episode of cardiac arrest was uneventful and she was ultimately discharged from the hospital on a schedule of digitalis sufficient to maintain a reasonably slow rate of ventricular response and thereby control her symptoms of failure.



Electrocardiogram—A regular sinus rhythm is present at a rate of 60 with somewhat broad P waves and a P-R interval of 0.18. Width of the QRS complexes varies from 0.06 in those with normal ventricular conduction to 0.14 in the others which probably represent an intermittent bundle branch block, sometimes recurring on alternate beats. The S-T segments are depressed at least 1 mm. in the left precordial leads where the T waves are inverted. While the Q-T interval is prolonged in the beats with abnormal ventricular conduction (by approximately the amount that their QRS complexes are widened) the measurement appears to be within normal limits in the others although it is difficult to determine just where the T wave ends and the U wave begins.

The large U waves, especially conspicuous in V_5 and V_6, are a prominent feature of the tracing.

Discussion—This case, perhaps more than the electrocardiogram, is representative of quinidine toxicity. Little can be said of the tracing except that it shows an intermittent intraventricular conduction defect of the left bundle branch block type and strikingly large U waves. The T and S-T changes are what one would expect in a patient receiving digitalis. Fortunately the patient survived what is usually a fatal complication owing to prompt institution of the recently popularized "closed chest" method of cardiac massage to maintain circulation and restore cardiac function following what was undoubtedly an episode of cardiac arrest.

Although quinidine has been used widely in the treatment of cardiac arrhythmias for more than a generation—mainly because of its principal actions of decreasing conductivity and irritability of the myocardium—considerable divergence of opinion still

exists as to its effects on the ECG as well as on the myocardium. For awhile the drug fell into disrepute and still is condemned by some as a "protoplasmic poison". Certainly its use in the treatment of ectopic arrhythmias and even as a prophylactic measure in acute myocardial infarction is attended by some hazard as this case illustrates. Such calculated risks can of course be greatly reduced by thoughtful observation of the patient and his electrocardiogram for indications of quinidine toxicity.

The "classical" ECG signs ascribed to quinidine are:

1. Prolongation of the Q-T interval—said to be the earliest and possibly the most consistent indication of quinidine effect. The same abnormality, one might recall, was described for hypokalemia until a few years ago when it was recognized that what was actually being measured was the Q-U interval, accentuation of the U wave being the real alteration caused by potassium deficiency.
2. Depression of S-T segments with flattening or inversion of T waves, not unlike those produced by digitalis.
3. Widening of QRS complexes—either because of depression of one or the other bundle branches giving rise to a bundle branch block, or by depression of the entire conduction network prolonging equally all portions of the QRS complex which consequently is of normal configuration except for the increased width. There is an old rule that one should use great caution in administering additional quinidine when the degree of widening reaches 25% of the width of the control QRS, and that a 50% increase is a mandate to stop the drug. From a practical standpoint, however, the degree of urgency ot the situation sometimes weighs heavily in that decision.
4. Broadening and notching of P waves—due to further depression of atrial conduction and intra-atrial block.
5. Complete suppression of atrial activity with the emergence of a nodal rhythm or ideoventricular rhythm or, if the depression is of sufficient degree that no area of the heart can take over the pacemaking role, cardiac arrest.

Not always does the patient experience the tinnitus, vertigo or nausea of cinchonism before ominous conduction abnormalities appear. As with digitalis therapy, the electrocardiogram may provide the first warning of impending disaster.

The large U waves are in all probability the prime warning of quinidine toxicity in this patient. They were not present before the drug was started nor after it was discontinued. Were it not for the fact that the intermittent bundle branch block persisted in tracings even two weeks later one might also attribute that to quinidine effect but a more likely cause here was the known coronary disease. Also the slowing of the rate to 60 is consistent with the depressant action of quinidine on the pacemaker. The much-feared complication of embolization—the dislodgment of thrombotic material from the atria when their fibrillation is abruptly supplanted by the normal mechanical contractions of a sinus rhythm—is actually a rare complication and was not a factor in this case. Just why the cardiac arrest did not occur until the day after restoration of a sinus rhythm when dosage of the medication had been reduced considerably is uncertain but it does suggest a more cumulative effect than one might expect with quinidine which is said to be quite rapidly excreted.

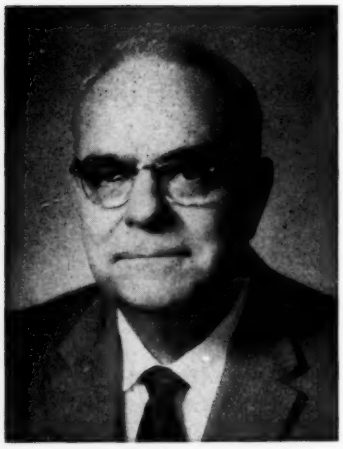
A helpful safeguard in quinidine therapy is that of retaining an electrocardiograph in the patient's room taking frequent strips of tracing as the dosage is increased to observe for signs of toxicity.

Parakeet as source of salmonellosis in man: Case Report—D. Kaye, H. R. Shinefield, and E. W .Hook. New Engl J Med—264:868 (April 27) 1961.

A case of salmonellosis is reported in which a parakeet was the probable source of infection. *Salmonella thyphimurium* was isolated from the stool of a 7-month-old infant with fever and diarrhea. Investigation of the patient's human contacts and food revealed no source of infection, but *Sal. typhimurium* was isolated from feces of a recently acquired parakeet. Bird droppings occasionally fell from the suspended cage to an area on the floor where the patient played. The bird feces contained 338,000 to 27,000,000 salmonellae per gram. No salmonellae could be isolated from air samples taken from the cage. Feces from 45 parakeets obtained from the wholesale supplier of the store from which the infected parakeet had been bought were negative for Salmonella. Further observations on the incidence of Salmonella infection in the parakeet would be of interest—there are about 15,000,000 parakeets in American homes today.

Spinal leptomeningeal ("Pial") lipoma: A case report by O. R. Talbert and C. N. Simmons (Charleston). Neurology 11:645, (July 1961).

A case of leptomeningeal ("pial") lipoma in a seven months old negro infant is presented. The tumor was confined to the subarachnoid space along the dorsal aspect of the spinal cord and lower brain stem, extending from the level of the rostral end of the medulla oblongata to the cauda equina, a 2.5 cm. section in the lumbar segments of the cord being spared. The clinical manifestation was that of paralysis beginning in the left upper limb and progressing to quadriplegia with death due to respiratory paralysis 31 days after onset of symptoms.



President's Page

On July 1, 1961, the Department of Public Welfare of this state implemented the Kerr-Mills law. Before and since this move has been instituted, there have been many inquiries as to how the doctor was to be paid. There is no provision in the law that pays the doctor, but there is no law that says that the doctor cannot charge a fee, if the patient can pay. The main purpose of the Kerr-Mills law is to provide hospitalization, nursing home care, and outpatient diagnostic care in a hospital for those 65 and over with an income of $1,000.00 or less annually. In other words, the Department of Public Welfare will pay for the above mentioned service on these "medically indigent" people when they are encumbered with unexpected hospital expense or nursing home care which their income cannot cover.

There are and will be some of these patients that can pay something on the doctor's bill, and in a case of this kind the doctor can and should charge the patient. The amount of the charge, of course, depends upon the circumstance of the patient or his family. In other words, the charges to these patients should be an individual matter, based upon the financial condition of the patient or his family. Certainly these patients are to be taken care of by the doctors of the state, whether they be completely indigent, can pay a reduced fee, or the regular fee.

The care of these people is no different from what it has ever been, and is within the ethics of our profession. It is hoped that this will help clarify the issue involved, and that the members of the South Carolina Medical Association may do their part in bettering the situation of these people and cooperate to the fullest with the Department of Public Welfare in making the Kerr-Mills law accomplish the ends for which it is designed.

Charles N. Wyatt

Editorials

HOT AND BOTHERED

J. Hampton Hoch, School of Pharmacy,
Medical College of South Carolina

Perhaps boiling mad would be a better caption for pharmacists' reactions to a sequence of events that came to a head in California late in June.

The July issue of the *Journal of the American Pharmaceutical Association* has full details of the federal court proceedings in which the U. S. Department of Justice prosecuted, or more exactly, persecuted, the Northern California Pharmaceutical Association and pharmacist Donald E. Hedgepeth on charges of violating the Sherman Act.

Their guilt was "promotion" of a prescription pricing schedule which incorporated a professional fee for dispensing or compounding prescriptions.

Actually the profession of pharmacy was on trial in Judge Louis E. Goodman's court—and so was every other profession which accepts the responsibility to compete on the basis of public service rather than price. Although Judge Goodman stated that professional services are immune under the Sherman Act—a point which the U. S. Supreme Court has not yet been required to rule on—he prejudged the suit stating that "I don't think that any experts would convince me that this (i.e. prescription filling) is a professional service. A prescription is only a piece of paper . . . . that requires no more professional service from the druggist than putting it in the package and delivering it". The judge's ignorance about pharmacy's professional services may be on a par with the lack of understanding likely to be exhibited by an uneducated person but is not what is expected from a person in his position. Ignorance is bad enough, but the judge refused to be enlightened by prominent physicians and pharmacists who were in court to shed light on the black and vacant recesses of the court.

The testimony of Drs. Rouse, Scheele and Klumpp was brushed aside as irrelevant and immaterial. The closed mind attitude of the Judge was a blatant factor bound to impress the jury. The prosecutor's use of Kefauverish tactics to inflame public opinion against pharmacy by wild allegations and attempting to show that poor sick people were *robbed* of over $3 million annually because pharmacists used suggested fee schedules was a more subtle maneuver. The condition and the tactic resulted in a verdict of guilty.

At this moment in history pharmacy may be a convenient whipping boy for some employees of the anti-trust division but they should be made to realize that everything that is politically expedient is not morally right. What happens to integrity in the health professions under defamatory proceedings such as this San Francisco burlesque? Despite legislative recognition of pharmacy's professional status the court has decreed that this is meaningless.

If our courts fail to support legislative recognition and restrictions granted to and placed on practitioners in the health professions where are we headed? If the dispensing or compounding of a prescription is not a professional service because it involves materials shipped in interstate commerce and this commercial fact takes precedence over other considerations, what is the status of an ampul of antibiotic (also in interstate commerce) when administered by a nurse or physician? Does the injection suddenly become a non-professional act because the ampul crossed state lines in arriving at the doctor's office?

It is difficult to understand the court's reasoning which held that because a pharmacist was employed on a salary basis and did not directly receive the fee portion of a prescription charge, the professional fee became the store owner's "mark-up" on a piece of merchandise. Does a professional service cease to be such when performed on a salary basis, e.g. in the U. S. Public Health Service?

Pharmacy's fight in this instance is important for all the health professions and their fee schedules.

Americans imbued with love and admiration for our republic, respecting the authority that we, the people, have granted to the judiciary, are not content to see legislative enactments suborned by the bench, twisted or extended in a fashion never intended by our elected representatives.

EYE DOCTORS

To a considerable segment of our population, any optometrist who advertises blatantly that with eye checking devices he can fit glasses is just as well qualified as the true ophthalmologist who must maintain the same professional reticence which is common to other elements of medicine. This poorly informed segment of people believes that the methods of the optometrist are adequate and that the care of the eyes which is rendered is equal to that of a graduate doctor of medicine. The existence of this situation has been a heavy cross for the ophthalmological profession to bear, and the solution of the problem is not in sight.

For several years, a pamphlet entitled "What Medical Authorities Say about Drops" has been widely circulated, principally through the offices of optometrists. This pamphlet attempts to discredit the use of cycloplegics in refraction, and the use of other drops necessary to the work of the ophthalmologist.

The pamphlet quotes six persons all purporting to be eminent medical authorities, doctors of medicine. It appears from a counterblast prepared by the National Foundation for Eye Care that the statements of the first pamphlet are entirely misleading, and that the "authorities" quoted are in no way entitled to the status claimed for them. Unfortunately, this rebuttal is not so easily transmitted to the public, and its message to a large extent is wasted in unproductive quarters.

It would seem that doctors of medicine would be sufficiently alert to the dangers of the situation that they would at least refrain from referring patients to optometrists, but it appears that such is not the case, and that a not inconsiderable number of our physicians patronize this class of technician. It is reported that even senior medical students occasionally take their personal eye problems to the optometrists rather than to the ophthalmologists. This would seem to be a difficult attitude to explain in people who must have been exposed recently to an exposition of the superior value of the ophthalmologist over the optometrist in all matters of eye care. Perhaps further enlightenment of the profession in general and of its students would be in order.

NEW ORAL THERAPY FOR TRICHOMONAS INFECTIONS

Medical World News° contains a description of an oral treatment for trichomonas infections. The report is based on an A. M. A. scientific exhibit at the annual meeting in New York. The exhibit reports the results of a study made at Duke University School of Medicine. This study follows a series of clinical reports from other countries, where the new drug has been used for several years.

The fact that the American study was done by the able and trustworthy group at Duke, lends significant credence to the trustworthiness of the report.

However, it is difficult to overcome a considerable degree of skepticism which has resulted from the failures after optimistic reports of, perhaps, a hundred successive treatment regimes, which have been reported in rapid succession for nearly fifty years.

There is a pressing need for a reliable form of therapy for the disturbing and embarrassing trichomonas vaginal infections. Although vigorous vaginal treatments of various kinds will result in amelioration of the symptoms, permanent cure is an entirely different and hard to provide result. Reinfection or failure to cure may result from sexual contact from an infected male, or the organisms may persist in the urine, or reinfection may occur from some other unrecognized source.

The terms used in various reports, namely: "Incredible but true;" "We didn't believe it (an oral dependable curative drug) could be made. Now it has;" "Given systemically (it) is effective in both female and male patients;"

2:16 (August 4, 1961)

"Not a single failure (in a series of 46 women and 20 men);" "In 44 treated patients, there were 44 cures;" are certainly reassuring but they are also strongly reminiscent of earlier reports of other studies which later gave rise to disappointment.

The Duke report will be published in the *American Journal of Obstetrics and Gynecology*. The drug, Flagyl, which was the therapeutic agent used in the various series referred to, is not yet on the American market. However, Searle will probably make it available soon. When that occurs, and after a careful study of the Duke report when it is published, a careful clinical trial will be warranted. In the meantime, be forewarned, for some one of the popular women's magazines is likely to publish an article on this "wonder" drug at any time. Don't allow your patients to be better informed concerning it than you are.

J.D.G.

THE NATIONAL FOUNDATION

Certain changes of policy by the Foundation in the recent past have appeared to many medical people to be of somewhat dubious quality, and it is apparent that what seemed to be an unwise expansion in the face of unmet established needs reduced materially the popularity of a long established charitable organization. Fortunately there has been some change of heart in the ranks of the Foundation, as may be seen by the statements appearing in an article elsewhere in this issue.

The development of Evaluation Clinics is planned to give aid to the physician who is handling difficult cases of arthritis and birth defects. A program which would furnish at the expense of the Foundation Chapters proper consultants to those who participate in the clinics, offer speakers to medical meetings, and perhaps individual consultation to physicians who for one reason or another may not feel the need of an Evaluation Clinic, would be of service to our doctors and our patients.

We have been assured that in the development of these new fields the old and still great responsibility of the erstwhile National Foundation *for Infantile Paralysis* will not lose sight of its original purposes.

HEARING ON THE KING BILL

A number of witnesses, including the Communist Physicians Forum, Inc., the International Association of Machinists, and the American Nurses Association, attacked the stand of the American Medical Association. Indeed, Allan M. Butler, M. D., past president and currently a member of the Board of Directors of the Physicians Forum, devoted most of his testimony to vitriolic attacks on the AMA and accusations against Ernest B. Howard, M. D.

In 1948 we referred to the nursing profession as "the soft belly of American Medicine." Through the years it has grown softer, more vulnerable. Nurses, as a group, are the least informed of the health professions with respect to legislation for national compulsory health insurance. They do not understand the meaning of the Forand and King bills, nor did they understand the Wagner-Murray-Dingell bills.

The American Nurses Association for many years has been dominated by past and present Federal officials and by the leading lobbyists for nationalized medicine. They placed implicit faith in Michael M. Davis, lobbyist for Federal medicine, for a long period. Then they turned to the leadership of Wilbur J. Cohen who has indoctrinated them through a series of misleading articles in their own professional journal. They are like a herd of bewildered sheep crowding around a wolf whose only intent is to devour them.

The ANA needs a complete overhaul. New officers and a new Washington representative might give the nurses of this country an opportunity to understand Federal legislation that would engulf them. How many nurses know that the King bill would shut out 44,000 private duty nurses? How many nurses have read the actual bill as against the unanalytical memoranda emanating from Helen V. Connors and Julia C. Thompson? How many nurses have gone to Great Britain to study nationalized medicine in action?

The ANA is using divisive tactics to drive a wedge between nurses and physicians simply because the latter have tried to explain the meaning of Federal proposals which the nurses do not understand. Dana Hudson, R. N., did a great service to her profession in denouncing the stand and the tactics of the ANA on August 1.

Challenge to Socialism

EASTER SEAL FAMILY CAMP

Sponsored annually in a mountain setting above Greenville, the Crippled Children Society of South Carolina operates the Easter Seal Family Camp for the purpose of providing carefully planned recreational activities for mentally alert, severely handicapped boys and girls who cannot go to other camps. Ramps and other facilities for wheel chair persons are provided.

Everything is good at Easter Seal Family Camp!

Not only is the Camp approved by the South Carolina Medical Association but that body provides medical leadership for the entire camp period. Now in its fourth year of operation the camp has won nationwide recognition and is accredited by the American Camping Association.

The program is planned especially for the cerebral palsied but other handicapped boys and girls, along with their parents, brothers and sisters, are eligible upon referral, provided they are mentally alert but too physically handicapped to be admitted to the Orthopedic Camp sponsored by the South Carolina State Board of Health or to a regular camp.

Top-flight counselors from State Health, Welfare, Education, Vocational Rehabilitation Departments and cerebral palsy specialists are on hand to assist with parent sessions. Subjects discussed include dressing and feeding techniques, discipline, and other phases of training of interest to parents.

Boy Scout and Girl Scout Councils choose outstanding Scouts to serve as volunteer "Buddies" to the Campers. The Scouts are given a three and one-half day intensive training session to prepare them for their duties.

Thomas G. Goldsmith, M. D., Greenville, was chairman of the Camp's Medical Committee. Serving with Dr. Goldsmith were Doctors William M. Shirley and Edwin H. Martinat of Greenville.

REPORT ON ACTIONS OF THE HOUSE OF DELEGATES AMERICAN MEDICAL ASSOCIATION 110TH ANNUAL MEETING

JUNE 25-30, 1961

NEW YORK CITY

Osteopathy, medical discipline, communications, surgical assistants, drug legislation, general practice residencies, relations with allied health professions and services, and poliomyelitis vaccine were among the major subjects covered by 115 resolutions and 28 reports acted upon by the House of Delegates at the American Medical Association's 110th Annual Meeting held June 25-30 in New York City.

Dr. George M. Fister of Ogden, Utah, member of the AMA Board of Trustees and previously a member of the House of Delegates, was named president-elect of the Association. Dr. Fister will become president at the June, 1962, annual meeting in Chicago, succeeding Dr. Leonard W. Larson of Bismarck, North Dakota, who assumed office at the Tuesday night inaugural ceremony in New York.

The AMA 1961 Distinguished Service Award was voted to Dr. Walter H. Judd of Minneapolis, physician and member of Congress, for his contributions as a medical missionary, humanitarian and statesman devoted to world peace.

Total registration through Thursday, with half a day of the meeting still remaining, had reached 56,315, including 22,681 physicians.

Osteopathy

In considering a report of the Judicial Council and three resolutions on the subject of osteopathy, the House of Delegates agreed with the intent of the report and resolutions, but instead adopted the following statement of AMA policy:

"1. There can never be an ethical relationship between a doctor of medicine and a cultist, that is, one who does not practice a system of healing founded on a scientific basis.

"2. There can never be a majority party and a minority party in any science. There cannot be two distinct sciences of medicine or two different, yet equally valid systems of medical practice.

"3. Recognition should be given to the transition presently occurring in osteopathy, which is evidence of an attempt by a significant number of those practicing osteopathic medicine to give their patients scientific medical care. This transition should be encouraged so that the evolutionary process can be expedited.

"4. It is appropriate for the American Medical Association to *reappraise its application of policy* regarding relationships with doctors of osteopathy, in view of the transition of osteopathy into osteopathic medicine, in view of the fact that the colleges of osteopathy have modeled their curricula after medical schools, in view of the almost complete lack of osteopathic literature and the reliance of osteopaths on and use of medical literature, and in view of the fact that many doctors of osteopathy are no longer practicing osteopathy.

"5. Policy should not be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test now should be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relationships with him should not be deemed unethical."

Medical Discipline

In a major move designed to strengthen the profession's disciplinary mechanisms, the House approved the conclusions and recommendations of the Medical Disciplinary Committee, with only three word changes. The House discharged the committee with thanks and commendation and directed that its functions be assumed as a continuing activity of the Judicial Council.

One recommendation suggests that "The bylaws of the American Medical Association be changed to confer original jurisdiction on the Association to suspend or revoke the AMA membership of a physician guilty of a violation of the Principles of Medical Ethics or the ethical policy of the American Medical Association regardless of whether action has been taken against him at local level."

Another "encourages and urges that each state association report annually to the American Medical Association all major disciplinary actions taken within its jurisdiction during the preceding calendar year."

The report urged state and county medical societies to utilize grievance committees as "grand juries" to initiate action against an offender so as to obviate the necessity of making an individual member of a medical society complain against a fellow member.

The House suggested that each medical school develop and present a required course in ethics and socio-economic principles, and that each state board of medical examiners include questions on ethics and proper socio-economic practices in all examinations for license.

The report concluded with a recommendation that "American medicine at the national, state and local level maintain an active, aggressive and continuing interest in medical disciplinary matters so that, by a demonstration of good faith, medicine will be permitted to continue to discipline its own members when necessary."

Communications

Acting upon four resolutions related to the Association's public relations program, the House adopted a substitute resolution directing the Speaker of the House of Delegates to name seven elected members of the House as a special committee "to study and

continually advise the Board of Trustees on the broad planning and coordination of all phases of communications of the American Medical Association, so that the public and the members of the medical profession are properly and adequately advised of the policies and concern of the medical profession with respect to all phases and aspects of medical care for all people."

The House agreed with a reference committee opinion that "we have a very adequate Division within the A.M.A. capable of implementing any program of communications." The approved committee report also said that "the Communications Division of the A.M.A. needs the active support and cooperation of the House and of all members of the Association."

Surgical Assistants

In considering a Board report and two resolutions on the subject of surgical assistant's fees, the House approved the following five basic principles developed by the Judicial Council and the Council on Medical Service:

"1. Each member of the A.M.A. is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

"2. Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

"3. No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

"4. It is ethically permissible for a surgeon to employ other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance.

"This principle applies whether or not an assisting physician is the referring doctor and whether he is on a per-case or full-time basis. The controlling factor is the status of the assisting physician. If the practice is a subterfuge to split fees or to divide an insurance benefit, or if the physician is not actually employed and used as a bona fide assistant, then the practice is contrary to ethical principles.

"5. Under all other circumstances where services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately."

Efficacy of Drugs

The House strongly endorsed a Board report which pointed out the problems that would result from amending the Food, Drug and Cosmetic Act to authorize the Food and Drug Administration to determine the efficacy, as well as the safety, of a prescription drug prior to the approval of a new drug application. The A.M.A. will oppose such legislation before the Kefauver Committee, the report pointed out, on the basis that "a decision with respect to the effectiveness of drugs is dependent upon extended research, experimentation and usage." The House agreed that vesting such authority in the Food and Drug Administration would operate to limit research, the marketing of drugs and the exercise of discretion by the medical profession. "The marketing of a relatively useless drug is infinitely less serious than would be the arbitrary exclusion from the market of a drug that might have been life saving for many persons," the House declared.

General Practice Residencies

Eight resolutions were introduced on the subject of creating new two-year, residency training programs in general practice. The House agreed that there appears to be a need for such programs for those individuals who desire more experience in obstetrics and surgery than may be available in the currently existing Family Practice Program. It approved a substitute resolution directing the Council on Medical Education and Hospitals to consider for approval other two-year programs in general practice which incorporate experience in obstetrics and surgery. The Council will review these programs on the basis of their individual merits and conduct a long-range evaluation of the new programs as well as the previously established Family Practice Programs.

Relations With Other Health Professions and Services

The House considered a Board report and twelve resolutions dealing with various aspects of medicine's relationships with allied health professions and services, including optometry. The Board report recommended the creation of a new A.M.A. Council to handle all the problems involved. The House, however, accepted a reference committee suggestion for establishment of a new Commission to Coordinate the Relationships of Medicine with Allied Health Professions and Services. The Commission will be composed of seven members appointed by the Speaker of the House. Subcommittees, composed of from three to five members selected by the Commission from lists of names submitted by the scientific sections, will consider problems in specific areas. The Commission will correlate and catalogue the reports of the subcommittees and will act as liaison agent between the subcommittees and those A.M.A. Councils where there may be overlapping interests.

Polio Vaccine

The House approved a report by the Council on Drugs on the present status of poliomyelitis vaccination in the United States and urged that it be made available to all physicians through the most effective communications media. The report clearly outlines procedures recommended for implementation of mass vaccination with the new oral vaccine when it becomes available. The House complimented the Council on its "clear and succinct statement on the initiation of the new campaign which will be needed to promote the new vaccine." The House agreed that the report provides the practicing physician with a reliable series of answers to the many questions which will arise during the change-over from Salk vaccine to oral vaccine. The report emphasizes, however, that "physicians should encourage, support and extend the use of Salk vaccine on the widest possible scale at least until the oral polio-virus vaccines currently under

development and clinical trial become available."

Miscellaneous Actions

In dealing with resolutions and reports on a wide variety of other subjects, the House also:

Approved the *"Guides to Physician Relationships with Medical Care Plans,"* submitted by the Council on Medical Service, with these two changes: deletion of item 5 under "Responsibilities of the Medical Society," which said "To recognize that properly qualified physicians employed by, or otherwise serving, medical care plans should not be denied professional rights and privileges because of their service to such plans," and addition of a new item 1 under "Responsibilities of the Medical Care Plan," which reads: "To provide the beneficiary of the plan with free choice of qualified physicians";

Reaffirmed its support of the *Kerr-Mills* program for the needy and near-needy aged and its opposition to any legislation of the *King-Anderson* type, declaring that the medical profession "will not be a willing party to implementing any system which we believe to be detrimental to the public welfare";

Approved a markedly expanded *drug information program* submitted by the Board of Trustees and the Council on Drugs;

Adopted the final report of the *Special Study Committee* of the Council on Medical Education and Hospitals and recommended that copies be sent to all medical school deans in the United States;

Decided to hold the *1963 Clinical Meeting* in Portland, Oregon, instead of Las Vegas, Nevada, as recommended by the Board;

Approved a plan by the new A.M.A. Department of International Health to cooperate in the recruitment of volunteer physicians for emergency medical service in *foreign mission fields;*

Agreed to an increase of $20 in the annual A.M.A. *membership dues* to be implemented over a period of two years: $10 on January 1, 1962, and $10 additional on January 1, 1963;

Discontinued the Association's *General Practitioner of the Year* award;

Opposed legislative and administrative mandates which would compel physicians to prescribe drugs, or require pharmaceuticals to be sold, by *generic names* only;

Reaffirmed the Association's opposition to compulsory inclusion of physicians under the *Social Security system;*

Urged immediate legislation that will provide strong economic motivation for the construction and maintenance of *fallout shelters;*

Disapproved two resolutions which would have discontinued the scientific activities at the *Clinical Meeting*:

Urged *immunization campaigns* against both tetanus and influenza, and

Asked state and county medical societies to give full support to the *First National Congress on Medical Quackery* to be jointly sponsored next October 6-7 in Washington, D. C., by the A.M.A. and the Food and Drug Administration.

Opening Session

At the opening session on Monday, Dr. E. Vincent Askey of Los Angeles, retiring A.M.A. president, challenged physicians and medical organizations to re-examine their own efforts to strengthen and improve medicine, and he warned against defeatism and failure to accept personal responsibility for answering criticisms. Dr. Larson, then president-elect, called on the profession to strengthen methods of self-discipline in both the state and county societies, adding that physicians must be concerned with improper or incompetent practice and unethical actions of all kinds. The 1961 Goldberger Award in Clinical Nutrition was presented to Dr. Frederick J. Stare, chairman of the Department of Nutrition at Harvard Medical School.

Inaugural Ceremony

Dr. Larson, in his inaugural address Tuesday night, said that the really good doctor, guided by the professional spirit, will always remember that medicine exists for just one purpose—to serve humanity. When the essence of that spirit is diluted or destroyed, either in an individual physician or in a nation, he added, medicine ceases to be a profession in the highest sense of the word. Dr. Larson also presented the Distinguished Service Award medal to Rep. Judd. Entertainment highlight of the inaugural program was a concert by the Montgomery County Medical Society Glee Club of Dayton, Ohio.

Election of Officers

In addition to Dr. Fister, the new president-elect, the following officers were named at the Thursday session:

Dr. Eustace A. Allen of Atlanta, Ga., vice president; Dr. Norman A. Welch of Boston, re-elected speaker of the House, and Dr. Milford O. Rouse of Dallas, Tex., re-elected vice speaker.

Elected to the Board of Trustees were Dr. Wesley W. Hall of Reno, Nev., to succeed Dr. Fister; Dr. Homer L. Pearson, Jr., of Miami, Fla., to replace Dr. Julian P. Price of Florence, S. C., and Dr. Charles L. Hudson of Cleveland, Ohio, to fill out the term of the late Dr. Cleon A. Nafe of Indianapolis. The Board named the following officers: chairman, Dr. Hugh Hussey of Washington, D. C.; vice chairman, Dr. Percy Hopkins of Chicago, and secretary, Dr. James Z. Appel of Lancaster, Pa.

Named to the Judicial Council were Dr. Robertson Ward of San Francisco, to succeed himself, and Dr. Elmer G. Shelley of North East, Pa., to replace Dr. Pearson.

Re-elected to the Council on Constitution and Bylaws was Dr. Walter E. Vest of Huntington, W. Va.

New Members of the Council on Medical Service are Dr. Charles Ashworth of Providence, R. I., succeeding Dr. Carlton Wertz of Buffalo, N. Y., and Dr. Burtis E. Montgomery of Harrisburg, Ill., to succeed Dr. Charles Hudson of Cleveland.

For the Council on Medical Education and Hospitals, Dr. Dwight L. Wilbur of San Francisco was

elected to succeed Dr. John W. Cline of the same city, and Dr. Kenneth C. Sawyer of Denver, Colo., was named to succeed Dr. Guy A. Caldwell of New Orleans.

F. J. L. Blasingame, M. D.
Executive Vice President
American Medical Association

THE NATIONAL FOUNDATION PROGRAM

William S. Clark, M. D., Director of Medical Care of The National Foundation (March of Dimes organization), has announced modifications in program policies. Following three years of extensive study, it was concluded that the patient aid program should provide a greater range of opportunities for Chapters to participate in meeting community health needs as they exist today and as they will develop in the future.

Polio will continue to be the first priority of the organization. Chapters are to enter direct patient aid in the fields of arthritis and birth defects only to the extent of their funds available beyond their polio responsibilities. Chapters have been requested to conduct their direct patient aid program on a pay-as-you-go basis from their share of their March of Dimes Campaigns, and are requested to minimize credit operations. Financial assistance for treatment of polio, arthritis, and birth defect patients is to supplement the financial resources of the family, insurance benefits, tax funds, etc., and only to the extent of Chapter resources. Patient eligibility is based on the patient's need for treatment, the cost of which would cause undue hardship to the family and when the patient is not eligible for adequate services from any other source.

The National Foundation Direct Patient Aid policies of 1960 in the fields of polio and arthritis continue basically the same but the following modification of policy in the field of birth defects is now effective: Policy changed from "Patients under 19 years of age with progressive hydrocephalus, encephalocele or symptomatic spina bifida" to "Patients under 19 years of age with congenital defects, exclusive of birth injuries." Assuming retention of the other limitations on eligibility and permissible Chapter expenditures, this one change should provide Chapters with new opportunities to expand gradually into the broad field of congenital defects in a more realistic manner.

The National Foundation program is designed to supplement but not duplicate services of other agencies in the fields of polio, arthritis and birth defects.

In addition to (not replacing) the traditional direct patient aid program, the NF is permitting selective programs embodying at the Chapter level a basic philosophy of the pursuit of excellence in the care of patients with chronic, disabling disease. This program would permit Chapters, with Headquarters' approval, to make annual grants to qualified hospitals in South Carolina for the following purpose: To promote, develop, improve, or expand diagnostic, habilitation, rehabilitation or consultative services in outpatient Evaluation Clinics for arthritis and congenital defect patients under 19 years of age. In addition to the above, selected activities permissible within present policies will be encouraged to help stimulate professional and public interest in arthritis and birth defects. These include: 1) Medical and lay symposia; 2) Short courses for professional personnel; 3) Medical speakers for professional meetings; 4) Community case studies.

These new policies take into account The National Foundation's continuing responsibility for polio patients, the compelling differences in birth defects and arthritis as compared with polio and the infinitely greater variety of medical problems involved, the essential emphasis on meeting qualitative instead of quantitative needs in the health field, and the unequal distribution of resources among Chapters.

National Headquarters will continue to assist financially indebted Chapters to the extent of its limited funds available for this purpose each year until previous polio debts are paid. During 1961 Headquarters has paid directly to hospitals in the seven southeastern states $282,000 on previously authorized polio bills.

The development in South Carolina of Evaluation Clinics is to be financed by Chapters that have available the necessary funds above their polio responsibilities and are thus able to make this investment for the development of the new program, aware that with the success of the program in the new areas there should be additional funds available to take care of previous commitments. This should redound to the benefit of the polio program as well as the two new areas.

Wilmer Sims, State Representative, The National Foundation, 1310 Lady St., Columbia, S. C.

AUTOMOTIVE CRASH INJURY RESEARCH IN SOUTH CAROLINA

At the 1961 annual meeting of the South Carolina Medical Association the House of Delegates approved and endorsed an automobile crash injury research program sponsored by Cornell University, in cooperation with the South Carolina Board of Health and the South Carolina Highway Patrol. Also on May 5, 1961 the Board of Trustees of the South Carolina Hospital Association officially endorsed this research program. In this new study which was initiated on June 1st, South Carolina became the twentieth state to collaborate in this interstate data-collecting system.

The purpose of this program is to obtain reliable data on the frequency, nature and specific causes of injury to occupants in passenger cars involved in automobile accidents. In addition, these studies are producing medical statistics which promise to implement treatment of auto crash victims through more definitive knowledge of the nature and scope of the problem. Data from other co-operating states have formed a basis by which automobile manufacturers have made important design changes in post-1955 passenger cars which are specifically engineered to provide occupant protection during accidents. Re-

liable information being obtained on the degree of protection offered by these items, which include the seat belts, springproof door latches, energy-absorbing steering wheels, padding, et cetera, is most encouraging.

The interstate research effort differs from previous highway accident studies in that it is seeking information on causes of injury rather than causes of the accident itself. Trauma produced in highway accidents is regarded as the mass disease which is as characteristic of our times as were bubonic plague, typhoid fever, and malaria in previous years. In studying this "disease," an epidemiologic approach has been utilized with the co-operation of medical societies, state Departments of Public Health and state police groups of Indiana, North Carolina, Virginia, Maryland, Georgia, Connecticut, New York, Vermont, Pennsylvania, Minnesota, Texas, Colorado, Michigan, Arizona, California, Oregon, Ohio, New Mexico, Illinois, South Carolina and Wisconsin which became the twenty-first state to join this interstate program on July 1st, 1961.

With carefully designed standardized data-gathering forms, the enforcement officers and the medical profession are contributing data from this "laboratory of the highways" to the Automotive Crash Injury Research group at Cornell, where a standard technique of evaluation and analysis is employed to identify the characteristics of the environment which produces trauma.

With the introduction by automobile manufacturers of new door lock designs, energy-absorbing steering wheels, specially designed energy-absorbing padding on the instrument panels, and forward overhead structure, as well as safety belts, the epidemiologic approach can now also be used as an objective measuring device to determine the degree of reduction in both the frequency and severity of injury that these changes are providing. Studies of post-1955 automobiles involved in accidents indicates the following:

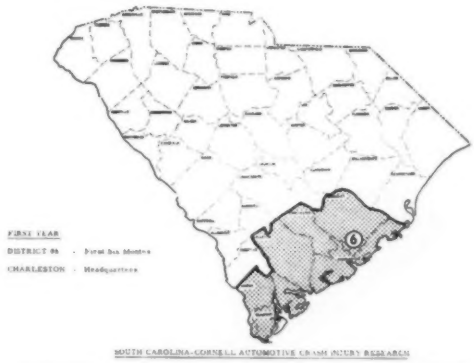
Door Latching Mechanisms: In the samples studied, the incidence of door opening in post-1955 cars was reduced as much as one-third in cars with improved latches, with the result that the frequency of ejection was reduced by about 40 per cent. The effect has been to reduce the risk of dangerous and fatal injuries about 12 per cent.

Findings Regarding the Ejection Problem: Common popular belief has been that "being thrown clear of the car" during an accident heightens one's chance of survival. Previous findings by Cornell have demonstrated conclusively that such is contrary to fact, and that the risks of death are increased nearly five times when a person is thrown from the car. If the annual level of traffic fatalities remains on the order of approximately 40,000, Cornell reports that conservatively estimated 5500 lives could be saved each year if ejection were prevented.

Steering Assemblies: As in the case of padding materials, data are still insufficient for statistical analysis. From available cases, clinical comparison indicates a reduction of severe chest injuries.

Seat Belts: When in use at the time of accident, seat belts are associated with about a 35 per cent reduction in the risk of major and fatal grade injuries.

Testimony in hearings before the Subcommittee on Traffic Safety of the House of Representatives on the use of seat belts, generally coincided with the position taken by the Automotive Crash Injury Research spokesmen on the efficacy of seat belts. The automobile industry has announced that starting with 1962 models, seat belt attachment points will be provided in all cars.



Studies in South Carolina are expected to represent an important addition to the interstate program in its continued effort to evaluate safety design changes and to produce data which can be useful as a basis for planning further safety design improvements. Standard statistical sampling techniques are employed involving the investigation of all injury-producing accidents in selected sampling areas. Individual areas are studied for periods of six months each and the South Carolina study is scheduled for a tenure of at least three years. The accompanying illustration shows the area currently under study. Mechanics of the program require that state highway patrol investigators fill out special reports for all injury-producing accidents in the current study area. Following his investigation of the accident, the state highway patrolman notifies the doctor or hospital having charge of accident victims that these cases come within the scope of the study. All physicians in these areas have been apprized of the study through letters from the President of the South Carolina Medical Association. Letters are sent to the Hospital Administrators by the Executive Director of the South Carolina Hospital Association and Hospital Administrators and their staffs receive further instructions from Cornell field personnel.

Medical forms are brief and do not require much of the physician's time. Upon completion they are mailed to the South Carolina State Health Department to be matched with related police reports and special photographs illustrating car damage details and injury

causes before forwarding to Cornell for analysis and statistical use. Serving as Medical Coordinator of this program is Dr. Hilla Sheriff, Director, Division of Maternal and Child Health of the South Carolina State Health Department. Earnest participation by the medical profession in this effort, which is aimed at solving one of the nation's foremost epidemiologic problems, is urgently requested. Unless the injuries of each person hurt or killed in the passenger car accident within the sampling areas is carefully recorded, the effectiveness of this study and the value of the subsequent data obtained may be seriously reduced.

Cornell Automotive Crash Injury Research studies are sponsored by the United States Public Health Service, and the Automobile Manufacturers Association.

By collaborating with Automotive Crash Injury Research, the physician will be furnishing the basic medical data necessary to combat this epidemic problem. Only with valid medical data can this mass disease be successfully attacked.

THE MONTH IN WASHINGTON

The American Medical Association cited more than 50 reasons why the vast majority of the nation's physicians believe the Administration's medical care program would be "bad medicine for the people of this country."

The A. M. A.'s objections to the proposal were spelled out in a detailed, 91-page printed statement presented to the House Ways and Means Committee by Dr. Leonard W. Larson, Bismarck, N. D., president of the A. M. A.

The committee held two weeks of hearings (July 24-Aug. 5) on the Administration proposal (H. R. 4222) which would provide limited hospitalization, nursing home care and outpatient diagnostic services for social security recipients. The program would be financed by an increase in payroll taxes on workers, employers and the self-employed.

Dr. Larson declared that the Administration program would force upon Americans a system of health care in which the quality of medical care would deteriorate, in which quality would become secondary to cost.

He said American medicine is the best in the world, medical education unsurpassed and the qualifications of U. S. physicians unmatched.

"Ours is a dynamic system of health care—and it works," he said. "The very fact that we now have 16½ million Americans 65 years of age and older proves that it works.

"Yet, this same system of medical care is now under attack. At a moment when American medicine is preeminent throughout the world, it is proposed that we adopt the very systems under which one European nation after another has lost its former leadership in medical science.

"The staggering costs of such plans, the administrative problems they create—let these considerations be secondary", he said. "The important thing is to see, at close range, the disruption of the doctor-patient relationship; the delays in admission to hospitals; the time wasted in the over-crowded offices of doctors; the regimentation of medical practice; the effect of the program on medical research; the availability of medical facilities and personnel—in other words, medicine in action on a government-run, assembly-line basis."

Dr. Larson said also:

1. Congress is being asked to plunge into a compulsory government-operated program of health care for certain of the country's elderly without knowing what even the first-year cost will be—whether $1 billion or $4 billion—and without any clear idea of the extent of the problem it seeks to solve.

2. The bill under consideration would give a single government official the power to "become the nation's czar of hospital care."

3. Contrary to statements of supporters of the measure that physicians' services are not included in the program, more than 50,000 doctors would be directly affected by regulations and controls exercised by government over operations and administration of hospitals.

4. Enactment of the program would "lower the quality of medical care available to the older people of the United States" because "it would introduce into our system of freely practiced medicine elements of compulsion, regulation and control" by government.

5. The Administration proposal is unnecessary in light of the true economic status of the aged and because of the spectacular rise of voluntary, private health insurance coupled with passage by Congress of the Kerr-Mills Medical Aid for the Aged Law last year and the existence of other public and private programs of aid to the needy.

6. Health care at the expense of the working people would be provided for millions who are financially able to pay for their own care.

7. The legislation "proposes that we distrust the brains and capacities of today's Americans" because "it suggests that the aged—as an entire group—are not capable of looking after their own affairs and providing for their own needs."

8. Increasing costs of the program could impose such a financial strain on social security that the entire system could be jeopardized.

9. The Administration's bill is just as objectionable as the five similar health care proposals rejected by Congress since 1942.

10. The bill would violate "American ideals of independence, self-sufficiency and personal responsibility" by establishing a system in which medical aid would be provided not on the basis of need but on the basis of age.

Dr. Larson described estimates of the cost of the Administration program as "confusing."

The A. M. A. president reminded committee members that HEW Secretary Abraham Ribicoff had told them that "a closer study" had revealed it would be

necessary to increase the taxable wage base from the present $4,800 to $5,200, rather than the $5,000 fixed in the bill when it was introduced.

He also pointed out that HEW originally had said nursing home services during the first year of operation of the Administration scheme would cost $9 million.

But in May, Dr. Larson said, HEW officials reported the figure as "unrealistically low" and lifted it to "somewhere between $25 million and $255 million."

"Obviously this estimate is something less than precise," Dr. Larson said.

The A. M. A. president said that supporters of the Administration proposal have built their case on five false premises: 1) that the sociological problems of older people can be solved through legislation; 2) that most, if not all, of the aged are in poor health; 3) that most, if not all, of the aged are verging on bankruptcy; 4) that the problem of the aged in financing their health costs will get worse before it gets better, and 5) that voluntary health insurance and prepayment plans, private effort and existing law will not do the job that needs doing.

DM

Announcements

SOUTH CAROLINA MEDICAL ASSOCIATION MEETING — 1962 MYRTLE BEACH

As this notice goes to press, the Chairman of the Program Committee is leaving for Myrtle Beach to discuss some of the necessary details of the 1962 program with Mr. Bauchner, the Manager of the Ocean Forest Hotel. Mr. Meadors is pulling the necessary strings in an effort to have a public address system in appropriate gathering places in the hotel to keep you informed about the progress of the program. Dale Groom and Cathcart Smith are calling upon their past experience to keep the machine moving smoothly. Charlie Wyatt and Robert Wilson, ex-officio members, are keeping us on the track. The Program Committee met again in late August to iron out the overall plan. Individual speakers and panelists will be contacted as soon as possible.

The response to our last request for suggestions, which appeared in the July issue of this Journal, has been of excellent quality. However, a little more "quantity" would now be appreciated. Your Committee wants you to have what YOU want. To borrow a phrase from Washingtonese, the plans will be "finalized" in September. Send us a letter or pick up the phone TODAY. We love to hear from our friends. Our enemies may be of even greater assistance.

Forde A. McIver, M. D., Chairman
Program Committee
16 Lucas Street
Charleston 16, S. C.

SOUTH CAROLINA CHAPTER— AMERICAN COLLEGE OF SURGEONS

Annual Meeting
November 1-2, 1961
Charleston, S. C.

November 1—Amphitheater of Medical College Hospital

John Steinhaus, M. D., Emory University—General anesthesia as a cause of cardiac arrest

Michael DeBakey, M. D., Baylor University—Renal revascularization

Winner of Contest among surgical residents will read his paper

November 2 (Founders' Day Seminar)—Baruch Auditorium

Dr. Steinhaus—Systemic effects of local anesthetics—toxic or therapeutic

Dr. DeBakey—Surgery of the carotid and vertebral arteries

Kenneth M. Lynch, Jr., M. D., Medical College of S. C.—Current management of renal tumors

THE MEDICAL COLLEGE OF GEORGIA

Five intensive postgraduate courses patterned for the practitioner are planned for the fall and winter 1961-62 at the Medical College of Georgia, Augusta, Georgia. Featured faculty will include nationally known figures as: Dr. Ralph V. Platou, Professor of Pediatrics and Head, Dept. of Pediatrics, Tulane Univ. School of Medicine, New Orleans, La.; Dr. Louis A. Goldstein, Associate Professor of Surgery (Orthopedics), Univ. of Rochester School of Medicine, Rochester, N. Y., and Dr. Darius Flinchum, Instructor in Surgery, The School of Medicine Emory Univ., Atlanta, Georgia; D. Michael Newton, Prof. and Chairman, Dept. of Ob-Gyn, Univ. of Mississippi Medical Center, Jackson, Miss.; Dr. Harold D. Levine, Peter Bent Brigham Hospital, Boston, Mass.; Dr. Champ Lyons, Prof. and Chairman, Dept. of Surgery, Medical College of Ala., Birmingham, Alabama.

Advances in Pediatric Diagnosis and Treatment, Oct. 31-Nov. 2, 1961; Fractures in General Practice,

Nov. 14-16, 1961; Obstetric Problems in Private Practice, Jan. 23-25, 1962; Cardiac Emergencies, Feb. 13-15, 1962; and Pre and Postoperative Care, Mar. 20-22, 1962. The courses will be supplemented by members of the faculty of the Medical College of Georgia.

Each course is acceptable for 18 hours of credit by the American Academy of General Practice and registration is limited to a small group for close participant-faculty communication. Registration fee is $50.00 for each session. Application may be made by contacting Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

International Symposium on Problems of the World's Children
Duke University — October 4-8

Announcement has been received of a symposium entitled "The Commonwealth of Children" which will be held at Duke University on October 4-8. Fourteen committees composed of Duke faculty members, officials, trustees and friends of the University are developing plans for the symposium which were conceived as a tribute to Dr. Wilburt C. Davison, internationally known medical educator and pediatrician, who directed establishment of the Duke University School of Medicine and served as its dean from 1927 until he relinquished that position last year.

Dr. Davison has advanced the welfare of children throughout our country and has inspired countless people with his compassion, ideals and standards of excellence. In planning the Symposium it was felt that no higher honor could be paid Dr. Davison than a demonstration that others would attempt to carry on his work to bring healthier lives and a better world to children everywhere.

The Symposium program will be built around half-day sessions on problems in education and culture, population and economics, and health and social structure. All these areas will be dealt with by experts brought together for the Symposium and each topic will be considered in its relationship to the welfare of the world's children. The program is being planned for a general rather than a specialized audience and all major sessions will be open to the public.

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Annual Meeting of Delegates and Assembly
Asheville, N. C.—Grove Park Inn—Oct. 12-14
Speakers

R. J. Moorhead, M. D.	J. L. Doenges, M. D.
Revilo P. Oliver, M. D.	E. R. Annis, M. D.
Charles Shuman	Hon. John Bell Williams
Col. W. R. Kintner	Tom Anderson, publisher

Deaths

DR. CURTIS PEARCY

Dr. Curtis Pearcy, 33-year-old anesthesiologist for the Colleton County hospital died August 8 at the Colleton County Hospital, after an illness of several weeks. He was born in Walterboro.

Dr. Pearcy was graduated from Wofford College in 1948, and the Medical College of South Carolina in 1952. He finished his residence in anesthesiology at Iowa State University in 1956. He was a member of the American Medical Association, American Society of Anesthesiology, and International Society of Anesthesiology. He was a member of Chi Phi Medical Fraternity, and Alpha Omega Alpha honorary medical society.

DR. W. C. CARNES

Dr. Walter Cecil Carnes, 50, Lancaster physician died of a heart attack July 13 at his cottage on the Catawba River, where he was recuperating from a heart attack suffered four weeks ago.

A World War II veteran, Dr. Carnes served with the United States Navy Medical Department in the South Pacific.

DR. EVERARD A. WILCOX

Dr. Everard A. Wilcox, retired U. S. Army surgeon, who retired to Beaufort in 1950 died at the Charleston Naval Hospital in July after a short illness. He was buried in Augusta, his home.

DR. JAMES O'HEAR

Dr. James O'Hear died in Charleston on August 4. He was born May 5, 1901 at Wando Plantation. He attended the College of Charleston and the Medical College of South Carolina.

He practiced medicine in Rhode Island for several years and took postgraduate work at Harvard School of Medicine.

Dr. O'Hear served in the China-Burma-India theatre in World War II as a medical officer in the Army Air Corps.

DR. W. R. DUKE

Dr. Wrightman R. Duke, 50, Dillon surgeon, died July 29 of internal injuries suffered in an accidental 15-foot fall at a pond at his country home near the Big Pee Dee River.

Dr. Duke came to the staff of St. Eugene Hospital from Texarkana, Texas, nearly two years ago.

He was graduated from Columbia University in New York and received his M. D. degree from Emory

(Continued on page 420)

News

GRADING FOR $350,000 GREENWOOD MEDICAL CENTER BEGUN

Grading has begun on an Alexander Avenue lot for a $350,000 Greenwood Medical Center, according to Dr. Stanley C. Baker, Jr., president of the Greenwood Medical Corp.

Dr. Baker says the project will be composed initially of three, one-story, multi-unit brick office buildings. A drug store and other commercial buildings probably will be constructed later.

Initial Medical Center construction is expected to be completed in the early spring of 1962.

The three buildings — and the commercial building when it is constructed — will go up on a lot across from the Alexander Avenue-Spring Street intersection near Self Memorial Hospital.

Dr. Baker says Medical Center buildings will house offices of every type medical specialist except a neurosurgeon and a dermatologist.

Other officers of the Greenwood Medical Corp. are Dr. Phillips Bates, vice president, and Dr. Richard Christian, secretary-treasurer, R. B. Curry, Jr., Greenwood businessman, is corporation business manager.

The center was designed by Jackson and Miller Architects of Columbia and will be constructed by Yeargin Construction Co. of Greenville. Dr. Baker says grading will be done by agreement and contract to the Yeargin firm was let August 1.

A hedge row joins the corporation's lot on the east, Abney Mills automotive shops bounds it on the west.

There will be sufficient room at the rear of the property to construct one or two additional units in the future.

The center will be composed of three buildings, which will be reached by driving through a driveway off Alexander Street into parking areas adjacent to each building.

Dr. J. Roland McKinney, Dr. John H. Kirkland and Dr. Casper E. Wiggins will occupy the office building nearest Alexander Street, which will be located to the rear of the drug store.

The second building will be occupied by Dr. Baker, Dr. William S. Brockington, Dr. Vernon B. Moore, Dr. Guy Calvert and Dr. T. Jackson Wood.

Dr. Paul Garrison, Dr. Bates, Dr. James A. Mc Quown, Dr. Christian, Dr. George H. L. Dillard and Dr. Caulie Gunnells will occupy the third office building.

The physicians are currently occupying offices in the Academy Apartments buildings. Dr. J. Furman Daniels and Dr. Elbert Adams also are moving into new offices, Dr. Daniels to a building going up on Wells Avenue and Dr. Adams to a new office on Spring Street on a lot adjacent to the Academy Apartments.

Planning of the Medical Center began about one and one-half years ago, Dr. Baker says.

SPEAKERS BUREAU

The following members of the Association have been added to the list of the Speakers Bureau of the Public Relations Committee:

Dr. J. P. Booker, Walhalla
Dr. W. R. Wallace, Chester
Dr. William E. Sims, Jr., Lancaster
Dr. W. J. Goudelock, Easley
Dr. C. J. Scurry, Greenwood

Dr. John Crawford Lipsey of Greenville and Dr. William Frederic Young of Sumter were certified as specialists by the American Board of Pediatrics, Inc., in March of this year.

Six new doctors have been approved for staff privileges at Anderson Memorial Hospital, and Dr. O. M. Goodlett, Jr. of Williamston has been added to the staff, according to Hospital Administrator George B. Little. The new doctors are Drs. J. R. Barham, W. L. Gilliard, Charles W. Hinnant, S. T. Haddock, Dr. Vernon Merchant who is associated with Dr. Olin Hentz, and Dr. Harold L. Murray who is associated with Drs. Clyde and Carroll Bowie.

Dr. Hartwell Hildebrand has begun general practice work with Dr. John L. Bundy of Rock Hill.

A native of Cameron, Hildebrand graduated from the College of Charleston and the South Carolina Medical College. After interning a year at the college's teaching hospital, he entered the Air Force and served at the Orlando AFB Hospital, Orlando, Fla.

He and his wife, the former Betty Thurmond of Orangeburg, and their 16-month-old son, Jim, moved to Rock Hill last week. They are living at 736 Hawthorne Lane.

STATE BOARD OF MEDICAL EXAMINERS OF SOUTH CAROLINA

The State Board of Medical Examiners of South Carolina held written examinations at the Columbia Hotel on June 27, 28, 1961. Seventy-three physicians passed the examinations and have been licensed. There were 66 graduates from the Medical College of South Carolina and 7 graduates from other medical colleges.

They are: Drs. Joel W. Allgood, Liberty; James S. Barr, Greenville; Richard H. Bendt, Charleston; Westley L. Betsill, Jr., Lake View; Thomas W. Blanchard, North Augusta; Maxcy C. Boineau, Adams Run; William L. Brennon, Jr., Denmark; Algie C. Brown, Greenville; William L. Bruns, Greenville; Henry B. Burton, Clinton; Harvey E. Butler, Jr., Conway; Thomas R. Byrd, Kershaw; Sydney E. Carter, Georgetown; Fountain S. Clare, III, Columbia; John DeV. Compton, Greenwood; Lollice B. Courtney, Aiken; Joseph H. Cutchin, Jr., Easley; Clarence S. Davis,

Jr., Florence; James D. Dennis, Spartanburg; Carla F. DuBose, Easley.

Also, Drs. William W. Duke, Lancaster; William E. Dukes, Honea Path; Julian B. Ellis, Jr., Mt. Pleasant; Skottowe B. Fishburne, Columbia; Joseph F. Flowers, Ehrhardt; James E. Gilbert, Aberdeen, S. Dak.; Hugh C. Godefroy, Grandmere, Canada; William H. Granger, Scranton; Casual D. Hammond, Florence; Alexis C. Higgins, Florence; John P. Jackson, Jr., Greer; Robert E. Jackson, Manning; Carlos A. Jaramillo-Dominguez, Augusta, Ga.; William P. Kay, Jr., Belton; George E. Lipscomb, Newberry; James F. Martin, Orangeburg; Sloan P. Martin, Jr., Anderson; Julian L. Mason, Jr., Marion.

Also, Drs. Bradwell R. McAlister, Charleston; Ann B. McIntosh, Cayce; Edwin McT. Meares, Greenville; Hiram B. Morgan, Jr., Ware Shoals; John R. Morris, Columbia; Richard L. Morrison, Georgetown; David W. Neville, Jr., Newberry; Walter M. Newton, Jr., Bennettsville; Benjamin E. Nicholson, Edgefield; George H. Nutt, Clemson; Daniel R. Pace, Marion; Hans J. Peters, Augusta, Ga.; Lucius C. Pressley, Jr., Chester; Thomas P. R. Rivers, Charleston; Harold E. Ross, Blaney; James E. Rowe, III, Manning; Lawton H. Salley, Orangeburg; Jack M. Smith, Florence.

Also, Drs. William K. Stacy, Jr., Anderson; Alva L. Strickland, Loris; Edgar E. Strong, III, York; Joseph T. Taylor, III, Charleston; Barbara A. Threatt, Rock Hill; Eugene T. Tragus, Spartanburg; Wiley H. Turner, Jr., Edgefield; Richard E. Ulmer, Hartsville; Norman S. Walsh, Moncks Corner; John L. Ward, Rock Hill; William F. Ward, Jr., Sumter; Thomas B. Warren, Jr., Allendale; Sidney H. Westbrook, Rock Hill; Robert L. Wingate, Jr., Columbia; Donald J. Wright, Anderson; Margaret L. Wyatt, Greenville; John J. Zadworny, Columbia.

Dr. Belton Drafts Caughman of Columbia entered into active practice in pediatrics July 1 at his office located at 1517 Hampton Street.

He is a graduate of the University of South Carolina, the Medical College of South Carolina, and completed a residency in pediatrics at the Medical College Hospital in Charleston.

Before beginning his residency training, he was on active duty in the U. S. Navy stationed at Coronado, Calif.

Dr. Mary Tribble Tobin (Mrs. Jos. A.) psychiatrist, Women's Service, Columbia Unit, S. C. State Hospital, recently resigned after having been on the hospital staff since 1954, as announced by the hospital superintendent, Dr. William H. Hall. Dr. Tobin immediately assumed the position of first woman physician at the Veterans Administration Hospital in Columbia.

R. C. Alverson, M. D. and William E. Alverson, M. D. announce their association in the practice of General Medicine. Offices in Professional Building, 122 Victoria Street, Greer, S. C.

DR. SOSNOWSKI NAMED TO ROPER HOSPITAL BOARD

Dr. John R. Sosnowski has been elected to succeed Dr. R. H. Hanckel on the Roper Hospital Board of Commissioners.

Dr. Hanckel resigned to accept a full-time position on the staff of the Medical College of South Carolina.

A Charleston native, Dr. Sosnowski is a graduate of Clemson College and the Medical College of South Carolina. His internship was served at Roper Hospital and he spent two years in the U. S. Army Medical Corps.

Dr. Sosnowski is assistant professor of obstetrics and gynecology at the Medical College.

As a new member of the board, his first assignment will be to head a group studying the hospital's practical nursing program.

Dr. Edwin K. Fennell announces the opening of his office at 2009 Hampton Street, Columbia for the practice of orthopedic surgery. Dr. Fennell was born in Columbia and educated in the Columbia City Schools. He was graduated from the University of South Carolina and the Medical College of South Carolina. He served his internship at the Methodist Hospital of Gary, Ind., subsequently entering the Army Medical Service where he was stationed at the American Hospital, Paris, France. On discharge from the Army he returned to the Medical College of South Carolina where he completed his specialty requirements in orthopedic surgery. He is married to the former Bette Burn of Charleston and they have three children.

Dr. Richard S. Owings, formerly of Columbia, has returned to Augusta, Ga., to practice pediatric surgery and will have a part-time association with the Medical College of Georgia as assistant clinical professor and instructor of pediatrics and surgery, as well as working with the Pediatric Surgical Section of the University Hospital.

He is a member of the staff of St. Joseph's Hospital, University Hospital and the Talmadge Hospital.

J. Earle Hodge, M. D., Winston Y. Godwin, M. D. announce the opening of their new offices at 701 Market Street, Cheraw, for the general practice of medicine and surgery.

Theodore J. Hopkins, M. D., Weston C. Cook, M. D., C. Tucker Weston, M. D. announce their association in the practice of Orthopedic and Traumatic Surgery at 1410 Barnwell Street, Columbia.

Charles W. Simmons, M. D. announces the opening of his office for the practice of Internal Medicine at 129 Congress Street, Suite A., Charleston.

Raymond Rosenblum, M. D. announces the opening of his office at 96-A Bull Street, Charleston for the practice of Urology.

DR. A. W. BAILEY ASSUMES POST

Dr. Albert W. Bailey, diplomate of the American Board of Pathology, assumed his duties as pathologist to Tuomey Hospital August 1.

A native of Augusta, Ga., Dr. Bailey received his primary and secondary education there. He took his degree in pre-medicine from Emory University and was graduated from the Medical College of Georgia with the M. D. degree in 1949.

His rotating internship at the U. S. Naval Hospital, Philadelphia, was followed by a residency in pathology at the University Hospital and Medical College of Georgia in Augusta. He has had five years active duty with the U. S. Navy.

For five years Dr. Bailey was a full-time member of the faculty of the Medical College of Georgia, where he held positions of instructor, associate and assistant professor of Pathology. He served as consulting attending pathologist at the Augusta Veterans Administration Hospital.

For the last year Dr. Bailey has been associate pathologist at Self Memorial Hospital in Greenwood. He is a member of the American College of Pathology, the International Academy of Pathology, the Intersociety Cytology Council, the American Medical Association, the Southern Medical Association and the New York Academy of Sciences.

Dr. Bailey is married to the former Dr. Ann L. Anderson of Lithonia, Ga.

DR. LEON E. HUNT BEGINS PRACTICE

Dr. Leon E. Hunt, a Winnsboro native, has opened a general practice here in Bishopville.

He joins Drs. Herman Denny and Leroy Dennis to become the third general practitioner in Bishopville.

Dr. Hunt was graduated from Clemson College. He later graduated from the Medical College of South Carolina. At this school, he held membership in the Phi Rho Fraternity.

Dr. Hunt served internship at St. Louis City Hospital.

Dr. Thomas T. Drake, Jr. of Anderson, who graduated from the Medical College of South Carolina and interned at Baptist Hospital in Memphis, will be associated with Dr. George W. Fort.

DOCTOR SIMONS HONORED BY LEE HOSPITAL COMMISSION

On May 28th, the Lee County Memorial Hospital Commission presented Dr. Sedgwick Simons a lovely silver pitcher engraved, "To Sedgwick Simons, M. D., in appreciation for fifteen years faithful service to the people of Lee County. Lee County Memorial Hospital Commission."

Dr. L. A. Nimmons made the presentation, beautifully expressing the appreciation of the hospital Commission of which the pitcher is a symbol.

Robert N. Milling, M. D., of Columbia, has joined the medical staff of the South Carolina State Hospital with assignment to the Admission-Exit Service, Columbia Unit, as announced by the hospital superintendent, Dr. William H. Hall. Dr. Milling has recently held the position of officer in charge, Field Epidemiological Research Section, National Heart Institute, Memphis, Tenn. He is a graduate of the University of South Carolina. He is residing with his parents, Mr. and Mrs. R. L. Milling, 4619 Monticello Road, Columbia.

Charles H. Banov, M. D. announces the opening of his office for the practice of internal medicine and allergy at 696 Rutledge Ave., Charleston, South Carolina.

Book Reviews

CONGENITAL MALFORMATIONS: A Ciba Foundation Symposium Edited by: G. E. W. Wolstenholm and C. M. O'Connor. Little Brown & Co., Boston 1960. $9.00.

This volume contains 12 papers with discussions, together with an introduction by the Chairman, and a long closing discussion summary. The topics covered include studies of the incidence of abnormalities, mongolism, chromosomal changes, teratogenic chemicals, runts, anencephaly, the effects of pre-diabetes and hypothyroidism and hydramnos.

It is one of the most fascinating and thought-prevoking books the reviewer has ever read, even when he admits there were parts he did not wholly understand. The vocabulary and mathematics of genetics are difficult for the clinical physician to follow. However, the clinical men participating have kept the varying subjects focused on the human aspects in all cases. Human experiments with teratogenic drugs are discussed also.

The book is not one for casual reading, but it will repay any one interested in the tragedy of the abnormal child.

James M. Wilson

A TRAVELER'S GUIDE TO GOOD HEALTH by Colter Rule, M. D. Dolphin Books, Doubleday & Company, Inc., Garden City, N. Y. 1960. Paper back 95¢.

A review of this book appeared in the May issue of the Journal. It expressed an endorsement of the value of the book for the traveling public. Now in paper back form at a low price the work becomes even more useful.

SOUTH CAROLINA MEDICAL ASSOCIATION
MINUTES OF THE
ONE HUNDRED AND THIRTEENTH ANNUAL SESSION
OF THE HOUSE OF DELEGATES

FRANCIS MARION HOTEL **CHARLESTON, S. C.**

APRIL 25, 26, 27, 1961

President — JOSEPH P. CAIN, JR., M. D.

2:30 P. M. Tuesday, April 25, 1961.
Call to order.
THE CHAIR: I will ask the meeting of the House of Delegates to come to order. (The Reverend Dr. Beverly Currin, Pastor of the Episcopal Church of St. Luke's and St. Paul asked the invocation.)
THE CHAIR: While we are waiting on the Credentials Committee's report I have a few remarks I would like to make. First I have this announcement that all the work that you fellows did over last week-end paid off for we have just received word that the Eclectic Medical Bill was killed 61 to 30 on the third reading.
I hope that this year we will be able to keep our delegations more together; you see we have assigned seats and I hope that they will be comfortable and a workable arrangement. Also each delegate has been given, in addition to the material already sent to him at home, another compact of the printed reports, mimeographed copies of the committee reports and other resolutions which you will find useful in referring to as the various reports and recommendations come in.

Reference Committees

I would like to go ahead now and read over the Reference Committees.
(Reading) Reports of Council and Officers—Dr. E. B. Poole, Chairman, Greenville. He is not present. I will ask Dr. B. F. LaBorde, of Columbia, to take over the chairmanship of that committee. The other members Dr. James A. Hayne, Dr. Grover Sheppard, and Dr. W. A. Wallace. Are they all present? (It was stated Dr. W. A. Wallace was not present)
We will try to fill in these committees as we go through the meeting, have them posted on the board. In case the full committee is not present, then we will expect those members of the committees, who are present, to go ahead and act in their absence.
(Reading) Legislation and Public Relations
Ripon LaRoche, Chairman, Camden
J. A. VonLehe, Walterboro
J. Harvey Atwill, Jr., Orangeburg
Harold S. Pettit, Charleston
George Wilkinson, Greenville
Public & Industrial Health
P. K. Switzer, Jr., Chairman, Union
T. C. Hankins, Dillon
Barney F. Timmons, Hartsville
R. Maxwell Anderson, Charleston
Amendments to Constitution and By-Laws
Frank C. Owens, Chairman, Columbia
Ben N. Miller, Columbia
Halsted M. Stone, Chester
Sam Cantey, Marion
Francis C. McLane, Ware Shoals

These minutes have been edited on instructions of Council. An effort has been made to eliminate the non-essentials. The proceedings are reported verbatim in a fuller copy in the hands of the Executive Secretary. — The Editor.

Insurance, Blue Cross, Blue Shield
John Arthur Siegling, Chairman, Charleston
George D. Johnson, Spartanburg
Robert S. Solomon, Moncks Corner
William H. Hunter, Clemson
Miscellaneous Business
Robert Clarke, Chairman, Due West
Frank B. Adams, Jr., Seneca
Joseph H. Cutchin, Easley
B. M. Montgomery, Newberry
A. R. Johnston, St. George

THE CHAIR: Do we have a Credentials Committee report at this time?
DR. PAUL S. WATSON, Chairman Credentials Committee: Yes, sir, we have 82 delegates listed, and 64 present, well over two-thirds.
THE CHAIR: Eighty-two (82) delegates listed, 64 present and accredited. I declare that a quorum is present and that we are now in official session.
THE CHAIR: At this time it is a very great pleasure for me to introduce to you your President-Elect for the next year. (Dr. Charles N. Wyatt comes to the rostrum amid applause)
Gentlemen, I am going to say this again Thursday night. I don't have to worry about you fellows being jumped on and egged on and pushed around just like I have been doing for the past year for I know Charlie is going to get right down to it and when he does you are going to get down to it. I feel very much relieved that I am getting rid of this job this year but I feel very good and confident that he is going to carry on the work just like I like to have it carried on. Charlie.
DR. CHARLES N. WYATT: Thank you very much, Joe. I know that taking over this job from this boy is going to mean a lot of digging and when the digging starts it is going to be passed out. I can't assure you that I will be as active as Joe has, he has traveled ten thousand or more miles, but I will come as close to it as I possibly can. I certainly thank you for the honor that has been conferred upon me and expect you to help me make this next year as good as this past year has been. Thank you very much.
THE CHAIR: At this time we are going into an order of business, which is not on the agenda. All of you this year have been interested, one way or another, in the subject known to some of us as re-registration and to others of us as various and sundry adjectives and modifiers, etc. In fact there was so much discussion concerning the subject of re-registration, as it was passed last year at the House of Delegates, that rather than try to have it implemented at this year's session of the legislature it was deemed wise that this be brought before the House of Delegates again for their pleasure. I will now entertain a motion for reconsideration or not, as the House of Delegates sees fit. If there is a motion made for reconsideration, it must be made by a person who voted for the measure last year, otherwise the motion is out of order.
I would like a joint motion, if such a motion is going

to be heard and presented and that is that the problem of re-registration be reconsidered and referred back to the Reference Committee. Do I hear such a motion? If not, I understand that re-registration is approved by all present and that it is to be implemented as voted last year?

DR. WILSON: Mr. Chairman, I move that the matter be reconsidered. (Seconded) (Request made that motion be restated.)

THE CHAIR: The motion was that the subject of re-registration be reconsidered by this year's House of Delegates and it has been duly seconded. (The vote was taken, the Chair ruled that the "Ayes have it" and it was so ordered.) I will refer the subject of re-registration back to the Reference Committee on Legislation and Public Relations.

Now, this is a matter of great importance to every one of you here present; it is a matter about which I have had more correspondence and conversation during the past year than any other one question that I know of. I will call your attention to the fact that when it is brought up to the Reference Committee that it is your duty to go to the Reference Committee and tell them whether you approve or disapprove or whether you would approve it in a different form. If you do not do this then whatever decision is made you will have assented to, by default, so I call your attention to the fact that the Reference Committee will be "Legislation & Public Relations" and we will tell you where that will meet before the meeting is over.

PRESENTATION OF RESOLUTIONS AND RECOMMENDATIONS—

THE CHAIR: Now is the time for presentation of resolutions and recommendations from individuals and from county societies. I would like at this time, following the discussion of re-registration, to yield priority of the floor to any county which has resolutions pertaining to re-registration so that we can get them all referred to the same committee. Does any county have any resolution?

Aiken County on Registration

DR. G. A. PODA, Aiken (Recognized)

THE CHAIR: We will ask Dr. Poda to read without preamble, simply the resolution, all preambles and discussions to take place at the Reference Committee this afternoon.

DR. G. A. PODA: The Aiken County Medical Society, after due consideration, would like to make this proposal on re-registration.

1. Every person lawfully engaged in the practice of medicine within the state as set forth in Sec. 1356 and Sec. 1363 and every person hereafter duly authorized to practice medicine in this state, shall, on or before January first of each odd year, apply to the Board for a certificate of biennial registration with the Board of Medical Examiners which shall be furnished by the Board, and shall pay at such time of registration a fee of five dollars, provided, however, that any physician who receives his license in the second year of any biennial period shall pay a fee of two and one-half dollars for a certificate of registration expiring on December thirty-first of such second year.

2. A physician in making his first registration hereunder shall write or cause to be written upon the application so furnished by the Board his full name, office and residence address, the number of his state license and such other facts for the identification of the applicant as a licensed practitioner of medicine as the Board may deem necessary, and shall duly execute and verify the same before an officer empowered to take acknowledgment of deeds, and deliver the same to the Board by mail or in person. Subsequent registrations after the first registration need not be upon a sworn application by the applicant, unless in any particular case the Board may with cause deem the application be made under oath.

3. Any licensed physician who fails or neglects to register prior to beginning practice or by January first of any odd numbered year as required by these provisions, shall be required to pay in addition to the authorized registration fee an additional one dollar for each month he is in default. Should such practice be maintained without registration, such physician shall be subject to a civil penalty, of one dollar per day such practice shall continue, and should same continue for more than one month from date of notification of delinquency the penalty shall thereafter be five dollars per day so long as said practice shall continue, said penalty to be recoverable in an action by the Attorney General of this State.

The penalties provided in this paragraph for failure, neglect or omission of a duly licensed physician to register under this section shall be the only penalties that may be imposed therefor, and the legality of his license shall not be affected thereby and such penalties may for good cause shown, at the discretion of the Board be remitted or compromised. Wilful refusal to comply with this section shall be dealt with as outlined in Sections 1373 and 1374.

4. By notification of the Board in writing, a practicing physician may request he be placed on a "Licensed but Inactive" status for reasons of entering into military or government service as outlined in Sec. 1372 or for prolonged illness or for reason of removing said practice of medicine from this state. Should such physician again resume the practice of medicine in this State, he should so notify the Board in writing of his intent and will then be placed on the "Licensed and Active" status and again shall be liable for the provisions of this section. The Board of Medical Examiners may request such information as deemed necessary to acquaint itself with the practitioner's activities during such absence, and finding no cause outlined in Section 1368 shall automatically register such applicant as outlined in paragraphs 1 and 2 of this section.

5. The Board, on or before October first of each even year, shall mail or cause to be mailed to every registered physician an application for registration addressed to the last known post office address of such physician, or may cause such application to be sent to such physician through the secretary of any duly incorporated medical society. The application shall be such as to contain proper spaces for insertion by the applicant of the information required under paragraph 2 of this section and also such directions as may be required properly to complete the application form. On February first of each odd year, the Board shall have mailed to any physician whose registration application has not been received a delinquent notice, calling attention to paragraph 3 of this section.

6. The Board shall issue to any duly licensed physician of this state, upon his application therefor in accordance with the provisions of this section, a certificate of biennial registration under the seal of the Board of Medical Examiners. Such certificate shall be valid for a two-year period commencing January first and expiring December thirty-first of the second year following except as provided in paragraph 1 of this section.

7. Upon the first of March in each odd year, or as soon as practicable thereafter, the Board shall have published and cause to be mailed to every registered physician in this state a printed list of all the duly registered physicians in this state, which publication will contain a current copy of the Medical Practice Act of South Carolina. On or before the first day of March in each even year, the Board shall likewise have published and mailed in like manner, a supplemental list of physicians duly registered thereunder

in this state since the date of the preceding publication, together with a list of those physicians whose addresses have changed since date of registration. Each such published list shall contain at the beginning thereof these words: "Each registered physician receiving this list is requested to report to the Board directly or to the secretary of any duly incorporated county or state medical society, the name and address of any person known to be practicing medicine whose name does not appear in this registry. The names of persons giving such information will not be divulged."
8. The names of physicians which shall in any year be added by the Board subsequent to publication of its list as aforesaid, shall be reported on request to the secretary of any duly incorporated state medical society of which county medical societies are components.
9. All registration fees collected by the S. C. State Board of Medical Examiners under this section shall be accounted for by such Board.
10. Each licensed physician shall conspicuously display his current and proper registration certificate in his or her usual place of practice at all times. Should a physician change the address of his usual place of practice, he should so notify the Board within 30 days, giving both his former and current address.

THE CHAIR: Thank you, Dr. Poda. That is the resolution from Aiken County Society and it will be referred to the Reference Committee on Legislation and Public Relations.

Are there any further resolutions regarding re-registration?

DR. JOEL W. WYMAN, Anderson, S. C. (Recognized): On behalf of the Anderson County Medical Society, and as delegates from that society, we move that the whole subject of re-registration be tabled.

THE CHAIR: Doctor, your motion is out of order. The subject of re-registration has already come up and it is before the house for reconsideration. You can make that motion in the morning, if you like.

Are there any other resolutions?

DR. WYMAN (Recognized) Mr. President, may we offer this in the form of a resolution?

THE CHAIR: You can offer it in the form of a resolution and it will be referred to the Reference Committee, yes, sir.

DR. WYMAN: May we do that?

THE CHAIR: The resolution from Anderson County Society is referred to the same reference committee on Legislation and Public Relations.

Are there any other resolutions other than those on re-registration?

DR. CHARLES WYATT (Recognized): This is a general resolution from the South Carolina Society of Pathologists which was given to me: The South Carolina Society of Pathologists requests that the committee of the State Medical Society for study of the Coroner-Medical Examiner systems be continued and strengthened rather than discontinued as asked in the latest report of the committee. It is felt by our Society that the complexities of present day medical-legal problems, require consideration of newer concepts such as Medical Examiner systems.

THE CHAIR: That will be referred to the Reference Committee on Legislation and Public Relations.

DR. MICHAEL PATTON, Spartanburg (Recognized): I would like to present on behalf of the Executive Committee of the Spartanburg County Medical Society the following two resolutions:

(The preamble to this resolution was not read by Dr. Patton, but is printed here)

Whereas, it is obvious that there are active and aggressive anti-physician socialistic and possibly communistic propaganda organizations such as those of the American Socialist Party, the labor unions and certain communications media vigorously fighting to socialize medical practice in the U. S. A.,

Whereas, these organizations utilize distortions, half-truths, deliberate falsifications and partial statements taken out of context in their efforts to attain their goals,

Whereas, medical organizations are employing only efforts aimed at improving public relations at the present time,

Whereas, the public in general is uninformed as to such facts as: the large portion of physicians' productive time given, without thought of compensation, to the care of the indigent; and the larger than average contributions of physicians to civic activities and charities, etc.,

Whereas, the efforts of medical associations toward improving relations are commendable, but are also not sufficient to attain the necessary ends,

And whereas, in order to prevent or even postpone the socialization of medicine, all physicians and others interested in preserving those few freedoms still left to us, must aggressively fight fire with fire

Be It Resolved that the South Carolina Medical Association go on record as recommending to the American Medical Association that the American Medical Association initiate an active and vigorous pro-physician propaganda program wherein the true facts relative to physicians and their activities be brought to the attention of the public, and that the American Medical Association be authorized and urged to use all means available to attain these goals, including the hiring of professional publicity personnel and the purchasing of time on the nation's radio and television networks.

THE CHAIR: Thank you, Dr. Patton, we will refer that to the Miscellaneous Business.

DR. PATTON (Cont.) The second resolution—It is requested through proper channels that legislation be initiated to the effect that a certified copy of the birth certificate of each newborn infant in the State of South Carolina, be automatically mailed, free of charge, to the parents or guardian of the infant after the certificate has been properly processed and recorded.

THE CHAIR: This resolution is referred to the committee on Legislation and Public Relations. Thank you, Doctor Patton.

Introduction of Officers and Guests of Woman's Auxiliary.—

THE CHAIR: Gentlemen, it is with a great deal of pleasure that I give you Mrs. George Smith, President of the Ladies Auxiliary to the South Carolina Medical Association, Mrs. Smith.

(Mrs. Smith gave an outstanding report of the work and accomplishments of the Woman's Auxiliary, outlining their growth and thanking Dr. Cain, President, for his valuable information and service through the year, also thanking the Advisory Council and Dr. O. B. Mayer, as well as her unofficial adviser, Dr. Thomas Pitts, and her own husband for giving her to us this year. Her report was enthusiastically received.)

THE CHAIR: I know you all will agree with me that was a wonderful report. The best part about it is that it really happened; she is not just talking. Those of you who have not had opportunity to work with the ladies, who call themselves the Auxiliary to the South Carolina Medical Association, have missed a lot. I have never seen such a bunch of eager workers, who want to do anything we want, you just tell them about it and they get to work. I am sure that next year we will have the same sort of leadership which we had under Mrs. Smith and I would like to take the opportunity to introduce to you the President-Elect of the South Carolina Woman's Auxiliary, Mrs. John Cuttino, Charleston.

MRS. CUTTINO: We are active members of the Medical Auxiliary because we have dedicated our-

selves to our husbands and their profession and we feel by doing female work we keep out of your hair. Through your projects and your program we carry out your advice for what you want us to do that can help you. I am looking forward with a great deal of pleasure to the next year when I will work under the direction and guidance of Dr. Charles Wyatt, whom I love so dearly and have respected so highly for years.

Officers of the Woman's Auxiliary: Mrs. S. Hayne Taylor, Greenville, treasurer; Mrs. McMurry Wilkins, Greenville, president-elect; Mrs. John T. Cuttino, Charleston, president; Mrs. Peter C. Gazes, Charleston, secretary; Mrs. C. Guy Castles, Jr., Columbia, 2nd vice-president.

THE CHAIR: I would like to have you ladies just stay with us. You know a while ago, imagine my surprise, about 30 minutes before this meeting started when I went into my so-called "presidential suite" and I saw two ladies sitting over there and I thought I had sure earned a bonus (laughter). They said, "Isn't this the meeting of the Student Loan Committee?" I said, "I am afraid not, but you are welcome to meet here if you like." I found out instead of being on the 8th floor in the presidential suite they were supposed to be in the presidential suite of the Ladies' Auxiliary on the 10th Floor.

Mrs. Smith and Mrs. Cuttino, we are very glad to have had you; if you are ready to go we will escort you out and if you would like to stay with us we would be very glad to have you.

MRS. SMITH: Thank you very much, it certainly has been a pleasure to be here with you and I will let you know we get even with Dr. Cain on Thursday morning, when he comes to report to us.

(Doctor ----------?) Recognized: I have a resolution from the Greenwood County Medical Society. We, the members of the Greenwood County Medical Society would like to request that a poll of the members of the S. C. Medical Association be taken as to the present wishes of members of the medical profession as regards to the Social Security System.

THE CHAIR: Thank you doctor, I will refer that to the Committee on Miscellaneous Business.

Are there any further recommendations or resolutions?

DR. GEO. D. JOHNSON: (Recognized) Mr. President, this resolution grew out of a little hassle we had this morning in Council. The subject is "Automobile Accidents."

Whereas, automobile accidents continue to cause many deaths in South Carolina, and

Whereas, in most of the accidents either speed or alcohol or both are the chief causes, and,

Whereas, the penalties for either or both are often so lenient that they offer no deterrent to further similar offenses, and

Whereas, our Highway Patrol Officers and local law enforcement officers must feel frustrated when they literally risk limb and life to apprehend the offenders only to have them released with little or no fine or imprisonment, now, therefore,

Be It Resolved that the South Carolina Medical Association urge the appropriate State Legislative Committee to require not only the usual tests for alcoholism but also urge that local magistrates impose sufficient fine or imprisonment for gross infractions of the law, and

Be It Further Resolved that a copy of this resolution be sent to the State Highway Patrol and the State Association of Law Enforcement Officers."

THE CHAIR: Thank you, Dr. Johnson, we will refer that to the committee on Public and Industrial Health.

Members of the Charleston Auxiliary register guests at the April Convention: Mrs. Leon Banov, Jr., Mrs. William B. Gamble and Mrs. Peter C. Gazes.

Reports of Officers

The Executive Secretary, Mr. Meadors. Mr. Meadors is in Columbia. He is on his way back by plane, he will be here soon. He called me a while ago to give you the news of the legislative victory and I am sure he will be here before we adjourn to give you his report.

We will now have the report of the Secretary.

DR. ROBERT WILSON, Secretary: (Reading)

Mr. Chairman, Members of the House, during the past year as Secretary of the Association I attended the Interim Meeting of the American Medical Association in Washington in November 1960. The most important topic for discussion at that time was implementation of the Kerr-Mills Bill by each state. This requires legislative action and appropriation by the Legislature but its benefits are so far reaching and profound that the State Medical Association should do all in its power to further such action.

Routine activities in the internal affairs of the Association are largely handled by the Executive Secretary, and to him the Secretary is indebted for his efficient management of these details. One of the duties of the Secretary is to act as a liaison officer between the Governor's office and the Association, and appointments by the Governor to the various Boards, on nomination of the Association, are often somewhat confusing. However, at the moment these appointments seem to be clear and in good order.

The Secretary acts as the Secretary of Council and most meetings have been attended. The Secretary

also has charge of placement service for physicians in the state and all such inquiries have been properly acknowledged. However, for this service to be of much value the Secretary is dependent on information from physicians in all parts of the state regarding their professional needs, and opportunities, and no such service is of much value unless the Secretary is kept apprized of this type of data.

I would like to remind the House of Delegates that it has been the policy of the South Carolina Medical Association to present a special award, a 50-year pin, to those physicians, not necessarily members of the Association, who have been in the practice of medicine in the state for half a century. A supply of these is in the care of the Secretary. They are usually presented to the member by the Councilor at a regular county society meeting, and if you will let me know to whom such an award is due, I shall be glad to forward a pin to the Councilor.

I would further stress the absolute necessity of all members of the Association keeping watchful vigilance on proposed legislation affecting physicians, both on state and national levels, and to be prepared to take appropriate action at a moment's notice.

Again I would like to acknowledge my gratitude to the House of Delegates for the opportunity of having served you as Secretary for the past year, and for this privilege I thank you all.

THE CHAIR: Thank you, Dr. Wilson, this report of the Secretary will be referred to the Committee on Reports of Council and Officers.

We will now have a report from our Treasurer, Dr. Howard Stokes.

DR. HOWARD STOKES: Mr. Chairman, Members of the House of Delegates, please refer to the brochure that has the pictures of Joe Cain and Dr. Workman on the front, you will find essentially my complete report. Looking down to the bottom of the left hand column you will find the revenue for the year $124,743.00. This included $30,624.00 collected for and remitted to the A. M. A. $6,207.85 collected and sent to the A. M. E. F., as well as $6,357.50 designated for the Permanent Home Fund. Membership dues in our state association amounted to $34,575.00 and funds received from advertising in the *Journal* were $39,518.92. I might add this was approximately $5000.00 less than it was last year, and this will be touched upon by the Editor of the *Journal*.

The excess of revenue over expenses for the year was $13,797.08. (This figure was adjusted in Reference Committee meeting to read $12,797.08 as shown on printed report of the Treasurer, last figure, righthand column.)

As of December 31, our investments amount to $77,874.55. Now, if you will go back up to the top of your Balance Sheet, the lefthand side, you will find our investments which read as follows: $10,585.06 in the Peoples Federal Savings and Loan Association, $47,547.61 in Investors Mutual Fund, $19,740.88 in the Investors Stock Fund, which last item represents the accumulated funds for the Permanent Home, making a grand total of $77,874.55. I think you will be pleased to know that as of December 21st the Association had a Bank Balance of $13,269.54. Thank you.

The Report of the Treasurer
South Carolina Medical Association
Florence, South Carolina

Balance Sheet
December 31, 1960

Assets

Current Assets:			
Petty Cash		$ 205.00	
Bank		13,269.54	
Accounts Receivable		2,729.26	
Total Current Assets			$ 16,203.80
Investments:			
Peoples Federal Savings and Loan Assn.		10,586.06	
Investors Mutual Fund	$47,547.61		
Investors Stock Fund	19,740.88	67,288.49	
			77,874.55
Fixed Assets:			
Furniture and Fixtures			8,340.40
Other Assets:			
Deposits			3.00
Total Assets			$102,421.75

Liabilities

Current Liabilities:			
Withholding Taxes			$ 245.38
Surplus			
Balance		$89,379.29	
Excess of Revenue over Expenses		12,797.08	
Total Surplus			102,176.37
Total Liabilities & Surplus			$102,421.75

Statement of Revenue and Expenses
January 1, 1960 to December 31, 1960

Revenue:			
A. M. A. Dues		$30,625.00	
Membership Dues		34,365.50	
Subscription Dues		3,903.50	
A. M. E. F. Receipts		6,207.85	
Advertising		39,518.92	
Permanent Home Fund		6,357.50	
Miscellaneous Income		1,475.50	
Benevolence Fund		50.00	
Directory of Members		216.00	
Interest and Dividends		1,713.36	
Gross Revenue			$124,433.39
Less Expenses:			
A. M. A. Conventions		$ 1,528.22	
Dues and Subscriptions		368.40	
News Letter		447.10	
Insurance		711.49	
Office Supplies		810.41	
Journal:			
Printing and Expense	$30,373.51		
Pro-rated Salary	304.00	30,678.51	
Salaries:			
Editor	3,000.00		
Exec. Secretary and Counsel	10,000.00		
Secretary, et al	7,867.50	20,867.50	
Postage		859.90	
Tel. & Telegraph		1,578.48	
Travel Expense		1,741.71	
Audit and Legal		620.19	
Public Relations Expense & Conferences		746.12	
Rent		1,200.00	
Taxes - Payroll		365.15	
Refunds & Transfers		1,538.75	
Misc. Expense		807.86	
Amer. Education Found.		9,178.00	
President's Office		1,220.99	
Woman's Auxiliary		1,224.83	
Maternal Welfare Com.		200.00	
Com. on Infant & Child			

Health	115.92	
Secretary's Office Expense	250.03	
Treasurer's Office Expense	150.00	
Com. on Public Relations	2,517.27	
Legislative Services	646.52	
Conference on Aging	87.96	
Benevolence Fund	550.00	
A. M. A. Dues Remitted	30,625.00	
Total		$111,636.31
Excess of Revenue over Expenses		$ 12,797.08

THE CHAIR: Thank you, Dr. Stokes, this report will be referred to the Committee on Reports of Council and Officers.

We will now have the report of Dr. Waring, Editor of the Journal. In addition to his report as editor he will report on the Public Relations Committee of which he is Chairman. Dr. Waring.

DR. JOSEPH I. WARING: Mr. President,

Report of the Editor of the Journal

During the past year, certain physical changes have been made in *The Journal,* including a new cover design, a little stronger cover paper, a different type of binding, and the use of lettering the spine of each issue so that it may be more readily identified.

Material still comes in somewhat sluggishly, but we have been fortunate in being able to keep a supply of articles for about three months ahead of schedule. This is very comforting to the editor, but sometimes it is a matter of question to the author who wonders why his article does not appear immediately upon acceptance by *The Journal.* Editorially, it would be very nice to have an even longer list of waiting articles, as is customary with a great many journals of states whose medical population is more eager to appear in print. *The Journal* is glad to receive a regular contribution of material from Dr. Dale Groom, and the irregular contributions from a number of other faithful supporters. To our regret, we get relatively little material from county societies in the way of news, announcements, etc., and *The Journal* could perform a useful function in making such matters public.

Through the kindness of some of our members, *The Journal* has been able to maintain a Book Review department, and it continues to solicit offers for reviews of books. How popular this portion of *The Journal* is with the readers is still a question. Indeed, it is always a question as to who thinks what about *The Journal* and what particular portion of it appeals to the bulk of our membership. The Editor is pleased to find that we have not infrequent requests from other journals for reprinting some of the original articles, and that even the editorial page is occasionally quoted.

A change in our position in regard to advertising has come about in the last year or so, very probably because of the Kefauver probings in the pharmaceutical manufacturers. There has been a very noticeable decline in the amount of advertising done in state journals, to the extent of perhaps twenty per cent or more. This is reflected in our journal and in the others, and while the situation is not critical, it must be a matter for careful consideration, as the financial basis of our journal is received from advertising. With lessened income it may be necessary to have a smaller journal. However, no change is anticipated at present, as there is an adequate support at this time.

The Editor would welcome any offers of assistance in any part of the operation of *The Journal.* Indignation, criticism, insult, and even an occasional kind word, would be welcomed. They all create material for publication.

THE CHAIR: Thank you, Dr. Waring, this report will be referred to the Committee on Reports of Council & Officers.

We will now hear your report as Chairman of the Committee on Public Relations.

DR. WARING: As you may recall, the duty of attempting to create and maintain and promote public relations was added to the Editor's activities a couple of years ago and we have endeavored to do what we could without being quite satisfied, that we have done as much as we might have done.

Report of The Committee on Public Relations

During the past year, the committee has pursued its activity in the way of production of television programs which covered a number of subjects of mutual interest to the public and the profession. These programs have been well received and the cooperation of the members of the Association who have been requested to participate has been very good in most places. There has been some favorable comment by the press on this series, and most of the television stations have been very agreeable to the donation of time on the air for the production of the programs.

Inasmuch as the demand on the various panels has been perhaps a little more than might be comfortably sustained, it was decided that the television program be gradually tapered off, with only occasional productions as circumstances indicated, and that the efforts of the committee might be directed more vigorously toward getting up a Speakers Bureau which would include the whole state. The purpose of this Bureau was to make available to local civic clubs, social groups, and other organizations the services of a physician who would talk about the same sorts of subjects which have been used on television. A number of suggested speeches have been prepared, mimeographed and distributed to those counties which have expressed an interest in cooperating in this program. These speeches were not intended to be delivered verbatim, but were to be used as guides for the speaker who might modify them according to his own ideas and local application.

During 1960, twenty county societies agreed to participate in the program and since then we have had two additions to the list. Most of the larger counties have entered into the effort.

As it was found that many of the local speakers or public relations appointees were somewhat loath to invite requests for their talks, a method was adopted whereby a list of miscellaneous possibly receptive organizations of various kinds was obtained from the Chambers of Commerce of the various localities, and these organizations were notified that the speakers were available upon request to the local representative of the program. This approach has appeared to stimulate activity, and while the committee has no statistical report to offer, since it has been unable to obtain much information from the local representatives, it feels that the effort has been well received and might well be continued.

The subjects of the talks have been varied; ranging from such things as accidents, poisoning, prevention of heart disease, etc., up to the more political subjects having to do with the care of the aged, and the Forand-type legislation. The committee is more than anxious to have criticisms, suggestions, and comments from the members, and to know whether its approach is agreeable to the Association.

The committee has also prepared for distribution to new members of the Association a pamphlet which contains a brief description of the activities of the Association which, with material from Blue Cross-Blue Shield and a number of pamphlets obtained from the American Medical Association, is to be distributed in a package to each new member as he joins. It is felt that this information may be worthwhile to many, especially to the younger members who have not too much knowledge of the activities of organized medicine.

The committee has also proposed and has received approval from the officers, that the new booklet prepared by the A. M. A. on the cost of medical care be distributed to all members of the Association and has sent a suggestion along with the booklet that those members who care to do so might accomplish quite a bit in the way of public relations by distributing these booklets to their patients. This distribution has not yet been effected, but should be accomplished very soon through the Executive Secretary's office.

THE CHAIR: Thank you, Dr. Waring.

This report is referred to the Committee on Miscellaneous Business.

Report of Council

The next report that we have is from Chairman of Council, Dr. James H. Gressette.

DR. J. H. GRESSETTE, Chairman of Council: Mr. Chairman, the Chairman of Council's report is kind of like a trash basket, it catches a little bit of everything, you know, you review, you go back over some things that you think you have already finished.

Council recommends that we have an amendment to the By-Laws, Section 3, which pertains to Emergency Medical Care and in this we would set up a committee. This would have to be an amendment of the By-Laws, and it will state how the members of this committee will be selected. I can read you this sheet of paper with it all in detail but I think we will just refer it to the committee.

DR. GRESSETTE: Another amendment to the By-Laws, Section 3, which has to do with an advisory committee to the Department of Public Welfare. This is a new committee, therefore we have to have an amendment to the By-Laws. And this would be an amendment setting up staggered terms for this committee to advise with the Department of Public Welfare at a state level.

Then we have No. 3, which is another amendment to the By-Laws, Amendment Chapter 8, Section 4, we propose that the Scientific Committee shall consist of three members, together with the President and Secretary, ex officio. The said three members shall be appointed by the President, and we recommend that these be staggered so that we can have some continuity to the Program Committee. We think that will make it much easier in procuring good speakers for this program.

THE CHAIR: These amendments, this portion of the Chairman of Council's report, will be referred to the committee on Amendments to the Constitution and By-Laws.

DR. GRESSETTE: Your Council has had a very active year. You know we appropriated money and activated the Benevolence Committee, we appropriated only a small amount of money, in Dr. Billy Smith's estimation, until we could get organized. We appropriated the sum total of thirteen hundred ($1300.00) dollars for the past year's operation of that committee until it could be further studied.

We have had a great many meetings pertaining to Civil Defense and I am glad to be able to tell you at this time you are fortunate in having Dr. Bushouse who is with us today to be our Civil Defense officer. He is back there by Dr. Wyatt. (Dr. Bushouse is asked to stand to let the doctors see him and is applauded)

We have had various other activities such as providing money for this coming year for the medical students to go to the student A. M. A. meeting. You are going to provide the cost of one delegate to that meeting which is the same amount which the Medical College provides for its delegate.

The Council has under way a study of the need of scholarships or grants for medical students and residents to try to see if we can make this field of medicine more interesting and more attractive to the young man who has his eye on a profession.

We have a committee activated to analyze and study the salaries of all who are on the payroll of your society and to report to Council whether they think they are too high, or too low or what not. And then we had this morning a very interesting report from the Cornell Automotive Crash Injury Research Committee that was presented by Dr. Moore and Dr. Sheriff with Mr. Marsh there, and this was quite a lengthy report. (To the Chair)

And then we have before the legislature at this time a South Carolina Adoption Law that Council thinks should be pushed by the society so that it will become law because we have none pertaining to how children are adopted.

We have had in the past year a very unusual and unique experience, the first time I have had such a great pleasure of being on the sideline watching one of our members go up the ladder in the officialdom of the A. M. A. Council is, and I know the House of Delegates is, very proud of Dr. Julian Price. He is now Chairman of the Trustees of the A. M. A. and in our humble opinion we think that he would make an excellent president-elect.

Council was petitioned by the Columbia Medical Society that they establish a first aid station at the State House during the time the Legislature is in session. This was discussed at length by Council and it recommends to the House of Delegates that they further study it and see if it is wise to establish such a first aid station at the State house.

Then we had another unusual situation. Very often we find among our members one who is very gifted and one who has an unusually keen sense about our needs and who recognizes whether we are wandering off of the straight and narrow, or whether we are getting a little on the liberal side or whether we are actually staying strictly on the conservative side, and Council has asked me that I ask your indulgence while I introduce to you one of our own, Dr. Tom Parker, and he is going to make us a statement regarding some literature "The Challenge to Socialism." Dr. Parker.

DR. TOM PARKER, Greenville, S. C.: Thank you gentlemen. Dr. Gressette, I want to speak to you about the "Challenge to Socialism" which is a medical news letter published by Dr. Marjorie Shearon, in Washington. Dr. Marjorie Shearon is a PhD. I believe in Chemistry. In 1930 she was an employee of the Social Security Department in which she worked under Isadore Faulk and W. J. Cohen, who has just been nominated and returned as Asst. Secretary to the Department of Education and Welfare. She finally got fed-up with what went on in that Department and resigned whereupon she was employed as legislative assistant by Senator Taft and she served under him in his office until there was a change in national parties and he ceased to be chairman of his committee, so he lost her services. She then started publishing this news letter which she has published ever since when Congress is in session, something like 30 or 40 issues a year, almost weekly when Congress is in session. It takes up matters dealing with medical legislation and social security. She is on our side. She has lost her husband with cancer this past year and she has always maintained that she wished to have freedom of choice of physicians. She and her husband published this letter together, they have sacrificed their life's savings fighting for the practice of private medicine. Her paper is not only informative but it is also reliable and I would like to suggest to the Association that it would be very helpful if the society saw fit to subscribe to her paper, or at least the members of Council. They would find it a source of reliable information on pending legislation and would

find things that they would not see in other places.
THE CHAIR: I refer the balance of Dr. Gressette's report, including the remarks by Dr. Parker, the Chairman will please take note of his remarks, to the Reference Committee on Reports of Council and officers.

I will ask Mr. Meadors if he will come up to the rostrum a minute I want to ask him a question. (Applause when Mr. Meadors goes to the rostrum) Jack, I presume this applause is for you, I want to ask you how did you do it?

MR. MEADORS: The answer is, Dr. Cain, I didn't do it, you gentlemen and the other doctors in the state did it.

THE CHAIR: Gentlemen, we will now hear the report of the Executive Secretary, if he is ready.

Report of Executive Secretary

MR. MEADORS: Mr. President and gentlemen of the House, it is always a pleasure to have the opportunity to come and make my annual report to this body and I do have a little unique and different pleasure in doing it this afternoon. We will come to that phase of it a little bit later.

It has never been our custom to burden the House of Delegates with a detailed report of the number of pieces of correspondence and other written material issued from our office, or other minute details of its operation. We have, however been guilty of some lengthy repetition in reporting on rather routine matters which vary little from year to year.

Because of the profession's interest in national legislative developments and those of the same type within the State, the volume of paper work has been considerably more than usual within the past year, and we have had more personal contact with members of the Association within the counties, due to an effort to cooperate with an energetic President in his extensive visitation program.

Your Association continues to grow in numbers and in the extent of its general activity. Forty-five new members have been added to the roll since January 1, 1961, for a total net membership of physicians in good standing at the present time, after deducting the few deceased and those who have moved out of the State, of 1559. The dues of more than 1050 members have been paid since the beginning of the year, both to the state Association and to the American Medical Association.

In the interest of brevity, the balance of this report will be devoted to information concerning specific activities considered to be of chief importance with which we have been engaged since the last annual meeting.

Other than the day-to-day conduct of the administrative business of the organization, the efforts to cope with Forand type legislation, in conjunction with efforts on the part of A. M. A. and other state associations, has demanded decidedly more interest and attention than any other one undertaking during the past year. The members have been kept generally informed on this activity through the pages of the *Journal*, the *Newsletter*, and otherwise. The American Medical Association, through its recently created Field Service Department, has devoted a great deal of time and effort in this area, and we have endeavored to cooperate and coordinate our activities with that program to the fullest possible extent. Several conferences on the subject have been attended, the most recent having been held in Chicago in March. The purpose of that conference was to review the profession's situation throughout the country, to assess so far as possible the extent of the support we have in the Congress in opposition to the provision of medical care benefits under the Social Security system, and outline the program for maintaining and increasing that support. We were pleased to be able to report at the A. M. A. meeting, attended also by the President Elect, Dr. Charles N. Wyatt, and Dr. Don Kilgore of Greenville, that we believe we can depend upon five Congressmen and certainly one Senator from our State to go along with the viewpoint of the medical profession.

Tied in closely with this effort has been the cooperation and development of further interest in other means of taking care of whatever needs actually exist for providing medical and hospital care for people over 65, in the hope, thereby, to make the Social Security proposals unnecessary and lessen the demand. Among the conferences attended last fall were two conducted by the State Legislative Committee on the Care of the Aging. That Committee, created by a Joint Resolution two years ago, conducted a statewide survey and, at the meeting held in Columbia in October for the purpose of framing the State's recommendations to the White House Conference in January, medicine's position was well represented; and a motion proposed by Dr. Cain, President of the Association, was adopted, expressing as the position of the entire meeting, views in line with those of the medical association.

Special emphasis has been directed toward securing implementation by necessary state legislation of the Kerr-Mills Law in South Carolina. After preliminary conferences with the Superintendent of the Dept. of Public Welfare, through which such a law would be administered, officials of the Association accompanied the Superintendent, Mr. Rivers, when he appeared before the Ways and Means Committee of the House of Representatives in Columbia for the purpose of presenting the proposal which would accomplish the desired purpose. Several weeks elapsed before the Committee acted, during which time our office was active in securing contacts with each member of the Committee and transmitting information developed from accurate studies and estimates with respect to South Carolina's needs, and we are pleased to report that the efforts of all those concerned, resulted, during the past week, in favorable action by the Committee, and the introduction on Tuesday, April 17th, of a Joint Resolution sponsored by the Ways and Means Committee, which, if adopted, will implement the Kerr-Mills Law in this State. Under this proposal, the amount deducted from the counties' share of the income tax would be increased from 30¢ per capita, as provided under the Spruill Bill two years ago, to 50¢ per capita, all of the amount to be turned over to the Department of Public Welfare and used with federal funds, according to the need throughout the State. The amount thus supplied would be supplemented by four times as much from the federal grant, and would be used to provide hospitalization, nursing home care, and out-patient diagnostic services to persons over 65 with annual incomes of a thousand dollars or less. The studies indicate that under this arrangement there will be made available to every county in the state more money for these purposes than the total that would be withheld from the county's share of the income tax, if the law is adopted. In view of this favorable financial situation; we are very hopeful that the proposal, sponsored as it is by the powerful Ways and Means Committee, may be adopted this year. It did not progress last week but may be reached for debate and action in the House within the next few days.

Within the past several years, it has been necessary to devote a disproportionate part of each annual report to discussion of the problems relative to cult practices. Although it would have been too much to expect that we could have escaped the difficulty this year, it did not develop until late in March, when Representative C. A. Mitchell of Oconee County

succeeded in having the House Committee on Military, Public and Municipal Affairs, of which he is a member, introduce as a Committee Bill, one that undertakes to define eclectic medicine, and which would provide him individually (since he is the only one in the State meeting the requirements laid down) to practice this nebulous branch of the healing arts. Our opposition was begun immediately. The necessary objection was made to have the Bill put on the contested calendar, and the officers of the various county medical societies and other physicians were alerted promptly. The bill was finally reached for debate on last Thursday morning and, despite the effort that had been made, and which was second only to that asserted in the original campaign to repeal the Naturopathic Law in this State, the Mitchell bill was passed by a vote of 55 to 40 on second reading. A renewed and intensified effort was immediately instituted over the week-end to oppose the measure when reached for third reading in the House.

Well, I can omit the last sentence in that paragraph now and bring you immediately up-to-date. And that is why I didn't discuss this before beginning the formal report. The bill was up for third reading this morning and was reached about one o'clock. It was debated in some considerable measure and I would like to say this—it is very fitting that our hosts here at Charleston, were the ones whose representatives carried the ball for us. Mr. LeaMond was on his feet immediately when the bill was called for consideration and made a motion to table the bill. Before doing so he took the floor and in a very forthright, frank statement, which in my opinion was the ideal approach for it, stated very frankly that last week this house, the House of Representatives, entirely or principally as a matter of friendship for one of their colleagues passed on second reading a piece of legislation which, as they all knew, should not have been passed. He pointed out his feeling and his sympathy for the fellow member but called to the attention of the members of the house that theirs was a more responsible position or situation, and called very strongly for opposition to the bill at this time and at the conclusion of his remarks made a motion to table it. At the request of several members he withdrew the motion long enough for some statement to be made, for of course, you know a motion to table cuts off debate. He withdrew his motion for the purpose of permitting statements and there were quite a few of them. I could not call all the names now and so there is no use to call any. Those who opposed it—there was considerable argument about what the actual position of the medical profession is. Mr. Mitchell had circulated a good many reports about the action in Oconee County and fortunately we were able in that we were sitting right near Mr. LeaMond in the back of the hall, to assure him that the Oconee County Medical Society in meeting last Tuesday evening had reaffirmed their position of complete opposition to the measure. After considerable further debate Mr. Augustine Smythe, also from Charleston, took the floor and made a very effective and spirited speech against the bill. Mr. LeaMond renewed his motion to table; demand for a roll call was made and the final count was 61 to 38 to table the bill, so that is that for this year; we don't have to worry about that particular bill any more for this year. That is a lot better than having it referred back to the Committee, which would have been the next step if that motion had failed, which a number of them were trying to get them to do. If that had been the case we would have had continual further difficulty to keep in touch with it.

We met regularly with the Insurance Committee, interviewed insurance company representatives and offered advice and assistance in consideration of the several programs of insurance proposed.

Since December, we have accompanied the President, Dr. Cain, on all of his visits to the county medical societies, and took advantage of the opportunity for personal contacts with the members at their local county meetings. While with one or two possible exceptions when it was absolutely unavoidable, we have been somewhat more difficult this year because one of the county organizations, we have had the opportunity this year to visit two or three of the county societies for the first time since our connection with the Association.

So far as we know, and with the exception of the legislative difficulties outlined above, the Association's affairs have been running smoothly and the climate of its various areas of interest is entirely favorable. Physical arrangements for the present meeting have been somewhat more difficult this year because of the facilities of the hotel. We regret that it was impossible to accommodate some prospective exhibitors who have been with us for a number of years, because of lack of space.

We cannot close the report without urging all members of the House to visit the exhibits and give the various company representatives a reasonable part of your time and attention. We would earnestly request, also, that you pass this request along to other members of the Association who are not here present but who will be arriving within the next few days.

Our usual thanks and appreciation for their courtesy, understanding and cooperation are extended to Dr. Robert Wilson and Dr. J. Howard Stokes, the Secretary and Treasurer, respectively, to Dr. Gressette, Chairman of Council, and to the other members of that body. Our Association with the President, Dr. Cain, has been one of the longest in an official capacity that we have had, and it is a source of personal regret that he concludes with this meeting his official activities, so capably handled and directed, first as Chairman of Council, and now as President of the organization. We wish especially to extend our sincere thanks and appreciation and that of the administrative staff, for his leadership, interest, his valued advice and cooperation in many of the difficult tasks undertaken since we have been connected with the organization.

M. L. Meadors

THE CHAIR: Thank you, Mr. Meadors. We would like to have you post the meeting places of the various reference committees.

At this time I would like to check to be certain my Chairmen of the Reference Committees are present: Pierre LaBorde, Ripon LaRoche, P. K. Switzer, Jr., Frank Owens, John Arthur Siegling, Robert Clarke (all were present) (It was stated from the floor that Dr. Charles R. May, Sergeant-at-Arms would not be present.)

I would like the Chairmen of these various reference Committees to pay particular attention to these referrals to their committees and check with the membership and if any members of their committee are absent we will appoint others for them.

I would like to refer Mr. Meadors' report to the Reports of Council and Officers.

Next we will hear from the Delegates to the A. M. A. I would like to extend the floor to our senior delegate Dr. William Weston.

Delegates to AMA

DR. WILLIAM WESTON: I gave a brief report to Council today. Dr. Waring has published both of the important items in the *Journal of the South Carolina Medical Association*, so I will have very little to say. In regards to the Mills-Kerr Bill that will be brought up elsewhere, and in regards to the Keogh-Simpson Bill, the Jenkins-Simpson, we do not stand much

chance of having that passed; that was a bill to allow the doctors to take off a certain amount of income if invested in insurance. We are considered as a minority group, which we are, and it would be a favored few, so my congressman, John J. Riley, says it will stand very very little chance of passing. Mr. President, I believe that is all at this time.

THE CHAIR: Thank you Dr. Weston. We will refer that report to the Committee on Council and Officers. We will now hear from Dr. George D. Johnson our other delegate to A.M.A.

DR. GEORGE D. JOHNSON: Mr. President, delegates, last year I was honored by being elected to the Council on Constitution and By-Laws of the American Medical Association. I say that only because when Billy and I receive an honor in the American Medical Association it reflects credit and honor to the South Carolina Medical Association. In conjunction with this new duty last week I had to go to Louisville. I was asked to go to Louisville to a medical legal symposium and I wish every doctor and every lawyer in South Carolina could have been there. This is not the place to go in great detail into what took place but there are a few points that doctors seem to forget: first, you and I practice under law, we receive our diploma under law, our practice is delineated by law and when a patient has had something happen to him that his doctor wouldn't have happen for anything on earth it is up to you and me to testify in the patient's behalf if we want to see justice done. Remember you and I carry malpractice insurance for two reasons, not only to protect us but to protect our patients when an accident is made. I wish you could have heard Mr. Louac, who is a partner of Mr. Berry, the famous man from San Francisco, who has so successfully sued so many doctors. The impressive thing to me was for every case of malpractice and negligence that you and I hear of, there are scores and scores that are turned down by your and my lawyer friends. In other words we most likely don't have near as good rapport with our patients as we think we do.

These recommendations that I am going to read are a summary of what transpired in the American Medical Association House of Delegates and they are recommendations and suggestions only:

Recommendations for State and County Medical Societies

1. All State and County Medical Societies should recommend names of qualified physicians for the various Councils and Committees of the American Medical Association. Such names, with a short biographical sketch, should be sent to Dr. Blasingame of the Headquarters office. States should publicize this information for the benefit of all physicians.

2. It is recommended that all constituent and component medical societies should consider developing liaison committees of state associations and county societies; that they be given increased responsibilities for exchange information and liaison; and that they be available equally to all legally constituted prepayment and/or insurance plans which do business in their respective areas.

3. It is recommended that all state associations bring to the attention of their members the suggestion for improvement in Veterans Hometown Care, Free Choice Veterans Care, Non-service-connected Admission Policies and State Association Action. It is further recommended that the public be informed of these policies.

4. All component medical societies should take an active interest in (a) assistance programs; (b) the whole complex of welfare medical care; (c) possible future developments.

5. All constituent medical associations should undertake a study of the need and desirability of establishing committees to assure the rendition of good medical care, to eradicate abuses of voluntary health insurance benefits, and to provide methods for the resolution of problems which arise in the provision of medical care to the public. Such action will identify the medical profession even more closely with its concern for the quality and cost of medical care and the utilization of benefits provided through voluntary health insurance mechanism.

6. The House of Delegates directed the Board of Trustees and the Council on Medical Service to assume immediately the leadership in consolidating the efforts of the American Medical Association with those of the National Association of Blue Shield Plans, the American Hospital Association, and the Blue Cross Association into maximum development of the voluntary non-profit prepayment concept to provide health care for the American people. Similar leadership should be undertaken to coordinate the efforts of private insurance carriers through conferences with their national organizations. Where feasible, efforts should be made to cooperate with other types of medical care plans, other professional groups and representatives of industry, labor, and the public at large.

7. Constituent associations should make every effort to effect the transfer of all professional services possible from Blue Cross Plans and all other hospital plans to Blue Shield or that section of insurance plans providing for professional services wherever such situations exist.

8. The House of Delegates encourages the state and local medical societies to promote High School Scholarship Award programs in their respective areas.

9. All state associations should cooperate with the appropriate state officials and provide leadership in implementing the provisions of the Kerr-Mills Bill.

10. State associations should nominate interested and experienced physicians for the position of "key man". This is the key man in state legislative affairs. The Woman's Auxiliary should be encouraged in their effective campaign assisting physicians.

11. State and County associations and societies shall participate in the promotion and publicizing of the scholarship and loan program proposed by the special study committee of the Council on Medical Education and Hospitals. The program will clearly assist in securing highly talented individuals whose ability and leadership in all areas of medicine will be fostered and at the same time will bring needed financial assistance on a broad basis to medical students under a system in keeping with the association's belief in individual responsibility.

12. Expansion of membership in the A. M. A. by state and county medical societies is important. We must actively seek to add all those currently outside our ranks so that we may truly represent the strongest, most united front possible as we face our responsibilities to the American people.

The Judicial Council has said many times and repeats here for emphasis: "The local medical society is the strong right arm of the medical profession. As it demands of its members respect for medicine's principles of ethics and as it demonstrates that its members are of high ethical stature, the public will respect and admire the profession of medicine and its members. If the county societies fail to require adherence to ethical principles, public admiration and respect for the medical profession will be lessened."

THE CHAIR: Thank you, Dr. Johnson, this report will be referred to the Committee on Reports of Council and Officers.

Gentlemen, we now come to the Committee reports. Some of these reports have been published in *The Journal*. At this time I will give the Chairman of these committees an opportunity to make a supplementary

report if he so desires. Otherwise the report will be referred by title to the appropriate committee.

Supplemental Report of Insurance Committee

Since submitting our former report, the Committee has had conferences and another meeting, the results of which are included in this Supplemental Report.

(1) After careful deliberation and discussion, the Committee decided to approve for recommendation a program of group life insurance for the members of the Association offered by Messrs. J. B. Talbert and O. E. Stubblefield, and underwritten by Home Security Life Insurance Company. While it is recognized that the plan is generally similar to the one offered members of the Southern Medical Association and, perhaps, other professional groups, this particular program contains desirable features which we have not found included in the others. First, the policies will be individually issued and guaranteed renewable and non-cancellable so long as the physician remains a member of the Association. During the initial enrollment period, the coverage will be available to all members of the Association in good standing without evidence of physical condition, provided a minimum of 40% of the membership participate. Following the initial period, of course, evidence of insurability will be required. Premiums compare favorably with those of other plans we have investigated.

(2) Also approved is a plan for major hospital expense coverage offered by Commercial Insurance Company of New Jersey, represented by the General Agency, Mr. John B. Cappelmann, Jr., of Charleston. This plan was proposed especially for the medical profession and it therefore offers reimbursement for major hospital rather than professional medical expense. Included is a substantial item for nursing care and other features. The premiums are considered very reasonable for the benefits offered. The plan can be put into effect if as many as 100 members of the Association subscribe and if 50% of the membership participates, will be made available to all members engaged in active practice regardless of medical history.

The same company and representatives also have an excellent program of disability coverage which they seek permission to offer, along with the policy for major hospital expense. This is not designed in any way to supplant the Association's present program with Educator's Mutual Insurance Company but is intended for those who may want additional insurance of this type. While the major hospital expense program is the main project of Mr. Cappelmann, and his principals, they propose to put that program into effect only if they are given the right to solicit also the disability coverage.

(3) Finally, the Committee made further study of the Retirement Plan offered by Mr. William Werber of Washington, D. C., through the Minnesota Mutual Life Insurance Company and discussed at some length in our original report. This plan, we are convinced, contains a flexibility which will appeal to many doctors. The rates are reasonable and it is the most advantageous of a number of contracts studied. Designed, as it is, to supply an appropriate vehicle by which to take advantage of a Keogh-Jenkins type law if that should be enacted, we believe that even without such legislation, many members of the Association will find it attractive.

The Committee respectfully recommends that the House of Delegates approve these three programs and authorize their presentation to the membership of the Association.

A. C. Bozard, M. D.
J. D. Gilland, M. D.
Kenneth G. Lawrence, M. D., Chairman

A. M. E. F.

DR. HOWARD STOKES (Recognized): Members of the House (Reading Report of A. M. E. F. Committee for 1960)

"Your committee has held several meetings, several by telephone and one in Charleston at which time Dr. Kenneth Lynch, Chancellor of the Medical College was present. At this meeting the importance of the A. M. E. F. was discussed and the part it was playing in the life of our medical college. It was at this meeting that it was suggested that a permanent committee of the State Association be formed so that the committee personnel would not be completely changed from year to year. This amendment will be presented at the end of this report.

The committee is pleased to report that the total grant for the Medical College of S. C. for the year of 1960 is $62,353.97, and a check for this amount will be presented to the College at this meeting. Of this amount only $5,207.32 was a general grant from A. M. E. F. This check represents one twentieth of the total amount of contributions to A. M. E. F., a remarkable situation when one remembers there are 85 medical colleges sharing in the fund. These funds are to be used at the discretion of the Dean of the Medical College in an effort to further the aims of the college in medical education. It is only proper that this association be reminded that more than 80% of the funds contributed came from the faculty members of the teaching college itself. It is heartwarming that over 600 members of the Association contributed to this fund but there is no reason why South Carolina should not have 100% participation in this case. The committee plans to continue its policy of reminding our State Association members about the A. M. E. F. and to concentrate on 100% participation. Credit for the success of 1960 is due in great part to the work of last year's committee under the direction of Dr. Edwin Boyle and his group.

R. L. Crawford
Thomas R. Gaines
J. Howard Stokes, Chairman

Dr. Stokes (Continuing) With the permission of the President I will also read the amendment to the by-laws. Amend Chapter 8, Section 3 of the by-laws by adding at the end of the list of Standing Committees another to be designated as follows:

(11) Committee on American Medical Education Foundation. Amend the said Chapter further by adding another section immediately after Section 13, to be numbered Section 14, and by renumbering the sections of said Chapter to conform. Said Section 14 to read as follows:

"The Committee on American Medical Education Foundation shall consist of five (5) members, three (3) to be appointed by the President of the State Association, the president and treasurer of the Association, ex officio. The three (3) members to be appointed shall serve initially one (1) for one (1) year, one for two (2) years and one for three (3) years, as designated by the Chairman of Council. The terms of all members thereafter appointed shall be three (3) years. It shall be the duty of this Committee to supervise the conduct of all publicity and fund raising for A. M. E. F., to receive the reports from A. M. E. F. together with the remittance of such funds as may be allocated for the Medical College of South Carolina, to transmit the same to the Dean of the School of Medicine, Medical College and to receive from him reports and information concerning the application of the funds so received. The Committee shall act in all respects as the connecting link between the Association, the American Medical Education Foundation and the Medical College of South Carolina. Its chairman shall be elected annually by the Committee."

THE CHAIR: Thank you, Dr. Stokes. I will refer the report of that committee to Miscellaneous Business and the amendment to the by-laws to the committee on Constitution and By-Laws.

SPECIAL ORDER—

THE CHAIR: Gentlemen, it is now 4:30, time for a Special Order. The Annual Meeting of the Corporation, The South Carolina Medical Care Plan.

I will call your attention to the fact that in a few minutes we will rise and when we sit again we will be sitting as the Corporation of Blue Shield and not as the House of Delegates of the South Carolina Medical Association. You will have a new presiding officer, Dr. George Dean Johnson, President of the South Carolina Medical Care Plan will be in The Chair. Before we rise and change hats I would like to remind you that this is the time to gripe and raise hell and anything else you want to say about Blue Shield and not next month or next winter when we all calm down. So I invite your comments, as long as I am not presiding (laughter) and I hope you will give George Dean hell. I ask you all to rise. (Convention rises)

DR. JOHNSON: Thank you very much. (Applause)

ANNUAL MEETING OF THE CORPORATION, THE SOUTH CAROLINA MEDICAL CARE PLAN

Presiding—Dr. George Dean Johnson.

THE CHAIR: Ladies and gentlemen, I declare the corporators of the South Carolina Medical Care Plan now in session.

There is no old business and I will give my report and ask for new business after that.

Report to the Corporators of the S. C. Medical Care Plan — April 25, 1961.

Your Blue Shield Plan is making more progress as time passes. Enrollment stands at the all time high of 71,310 contracts or 191,307 members. You will be interested to know, as was forecast last year, only about 1700 subscribers over 65 availed themselves of the old age medical care policy offered by your plan. Most of these signed up during the no restriction period when it was first opened to the public.

About 90% of practicing physicians in South Carolina will have signed up by the end of this calendar year. This is due not only to a better understanding of the plan but directly to the efforts of Bob Tomlin, the physicians' relations representative.

Financially your plan is in excellent condition—much better than Blue Cross. Your reserve has reached a satisfactory level and is invested in government bonds and in insured Building and Loan Associations. During the past year payments for certain procedures have been increased in order to meet the competition from some companies. Other benefits to subscribers as well as larger payments to physicians will be considered as time passes. So far anesthesiologists have not considered it wise to join with other physicians in this effort to forestall federal supervision and yet the President of the American Association of Blue Shield Plans is a practicing anesthesiologist in Washington. Roentgenologists are hesitant to enter into an agreement with your plan because they feel that reducing their fees by a percentage will simply reduce their income and in some instances not pay their cost. It is sincerely hoped that in the future these as well as other physicians will not feel suspicious of their colleagues who are trying to improve the only known method at our disposal to prevent federal control.

Let's glance for a few minutes at the national picture of Blue Shield. In June of last year, the House of Delegates of the A. M. A. approved a report of the Council on Medical Service which set forth specific proposals for closer relationship between the A. M. A. and Blue Shield both locally and nationally. In December at the interim meeting, the House of Delegates passed a much stronger resolution to the effect "that the House of Delegates direct the Board of Trustees and the Council on Medical Service to assume immediately the leadership in consolidating the efforts of the A. M. A. with those of the National Association of Blue Shield Plans, the American Hospital Association, and the Blue Cross Association into maximum development of the voluntary non-profit prepayment concept to provide health care for the American People." A similar resolution concerning coordination with private insurance carriers was made at the same time.

The publicizing of doctors' attitude towards freedom of choice and freedom from federal supervision must be done by the physicians themselves. It might be wise to follow the example of the Oklahoma physicians. In every county there is a Member Council composed of a cross section of people from the community. Every month these councils meet—3000 people—and discuss the burning topics of medicine: cost, utilization, sickness. The three groups most concerned with medical care try to thrash out the proper answers. The groups involved are the people, the hospitals, and the medical profession.

In certain parts of our state television programs have been put on by physicians. More of this is needed if we are to portray the proper image of the physician as we see him.

Utilization is not only filling our hospitals but weakening the financial structure of Blue Cross. If a man has hospital insurance and is sick enough to be hospitalized certainly he should get all the benefits of hospital insurance to which he is entitled. By the same token, he should not be allowed to stay any unnecessary days because that is why we in South Carolina have the highest utilization in the southeast. In the larger hospitals admission review committees should be set up to cut down excessive utilization. The high cost of medical care will bring on federal control more quickly than anything else. It is to our personal gain that we see to it that utilization is kept within reasonable and proper limits.

Every month sees improvement in the central office in Columbia. Most of the delays in payment are due to a necessary time lag for the medical director's review. There is, and, I suppose always will be, a difference of opinion between the medical director, and the one who performs the procedure. The more clearly and accurately and compresensively a procedure is described, the better will the medical director be able to decide the proper payment in keeping with previous similar procedures. Blue Shield is the physicians' plan and we are in much better position to improve it than we are any other. Let's all pull together to make it the best and most efficient in the business.

My term as a member of and President of Blue Shield ends with this meeting this afternoon. I have served on the Board since it was started and I have requested that I not be considered to succeed myself. I cannot praise Mr. Sandow enough especially and his colleagues who have brought our plan out of chaos to a smoothly operating efficient organization. Neither they nor we are content or smug or satisfied but we know great progress has been made and we all seek constant improvement. I wish to thank them as well as all the members of the board with whom I have had the privilege of serving, and I especially thank the laymen of the Board. To all the physicians in the state I am indebted. Our views have often clashed but never our aims and desires for the best possible medical care at a reasonable and proper payment to the physician. Blue Shield shall always be close to my heart and I shall seek every opportunity to advance

its interests as I have in the past. Thank you very much!

Mr. Sandow does not have a report, as such. If there are any questions or any comments that you would like to make at this time, if I can't answer them I am sure that Mr. Sandow or Dr. Guess or Dr. Charlie Lemmon can. Does anyone have any questions or comments? If there are none I would like to ask Dr. Guess to please come forward, Dr. Decherd Guess. Dr. Guess didn't know this was going to happen to him and he went out without realizing that he was going to be on the program. At the last meeting of the S. C. Medical Care Plan a committee was appointed, a committee of his home town neighbors who know him better than anybody else; they were asked to draw up appropriate resolutions on his retirement from Blue Shield and it is my great pleasure to read it to you now and present it to him.

"*Whereas,* Dr. James Decherd Guess as Chairman of the South Carolina Medical Association Committee which studied and formulated the Blue Shield Plan in South Carolina, was a major instrument in its founding,

Whereas, he was elected the first president of the South Carolina Medical Care Plan upon its incorporation in 1949 and continued to serve as its president through the difficult years of its birth and growth, and

Whereas, when it was established he accepted and ably carried out the additional duties of Medical Director of its claim department.

Now therefore be it resolved that we, the members of the Board of Directors, hereby commend Dr. J. Decherd Guess for his constant and considerable service to this board in its planning, for his stimulating leadership and for his unfailing devotion to the welfare of the South Carolina Medical Care Plan and the citizens it serves,

Be it further resolved that the personal gratitude of each member of this board be tendered to Dr. Guess along with good wishes for his health and happiness.

S. C. Medical Care Plan
George Dean Johnson, President
for the whole.

DR. J. DECHERD GUESS: President Johnson, members of the corporation. This is indeed a surprise to me and it is a surprise for a good many different reasons. One of the principal reasons is that I have been honored and recognized in so many different ways by our Blue Shield Plan before this. When I gave up the presidency, by request, the presidency of your Board, the Board presented me with a very very lovely memento, a lovely silver bowl which my wife and I prize; and then when some six months ago I presented my resignation as medical director of the plan to the executive officers of the plan, Mr. Sandow and his group, I was again recognized very very beautifully and sincerely at the annual Christmas party of the employees of the Blue Cross Plan. This comes as an additional surprise, perhaps this is like supercargo, too much, it is too much to do for any one man but I do appreciate it. But, what I was going to rise to say, before you called me up here—these nice things said on this piece of parchment will in no wise compensate me for the sorrow that came when Dr. Johnson announced that he was retiring from the Board and from the presidency as well. That was a shock to me. I am sincerely sorry and I am sure that you gentlemen on the Board will be when you have time to think it over, if not already, that he is retiring from the Board and as its executive head because from the very beginning he has been a most faithful and a most efficient member of the Plan, a man who has exercised remarkably sound judgment though starting off, as all of us did, with no knowledge at all of Blue Shield insurance, but studied, made it a study, and has come up to be a very very fine executive and director. And I am very sorry. I suppose, I don't know, as this business progresses maybe somebody will get him to change his mind or refuse to accept his resignation or something else. I would like very much to see him continue as a member of our Board and if possible to have him as president—because, if we don't he will be entitled to things equally nice or nicer than I have gotten.

DR. JOHNSON: I am like Dr. Guess, I leave the Board in the thorough understanding that it is in very capable hands and I am sure that my place will be easily filled.

As you know, nominees for the Board are placed in nomination by the Chairman of Council, unfortunately you do not have a chance to decide whether they are the proper ones or not but if enough noise is made we can put up some more names. I will ask Chairman of Council, Dr. Gressette, to come forward and place in nomination the names of the candidates, Dr. Gressette.

DR. GRESSETTE: This is a piece of paper that George Dean gave me (laughter) he said, "you are to read it." (Reading) To succeed themselves: Dr. A. C. Bozard, Mr. Dill Ellis, Dr. Charles Lemmon, Mr. A. P. Nisbet and Mr. C. Vandiver. I move that these be nominated to succeed themselves.

THE CHAIR: All in favor of the candidates as suggested, please say "aye". (The vote was taken, it was unanimous and it was so ordered.)

DR. GRESSETTE: Now, there is one other place to be filled on that, and that is Dr. Johnson's place. I would like to say I can use Dr. Cain's older daughter's nickname to tell you we "Ditto" what Dr. Guess said and I reluctantly follow your instructions and I would like to prevail on you, for Council, to remain a little while, stay with us and reconsider. Dr. Luther Mace to succeed Dr. Johnson.

THE CHAIR: Gentlemen, I appreciate the kind remarks Dr. Guess and Dr. Gressette have made. This move on my part is not without a great deal of thought and deliberation and I am spread pretty thin already and I can't do justice to the things that I am already in and this is one of the things that I think is doing very well and certainly can get along splendidly without me, and I ask that you vote now on the nominee, Dr. Luther Mace to succeed me. (The vote was taken and unanimously passed.)

(SPECIAL ORDER CONCLUDED) MEETING OF HOUSE OF DELEGATES (Cont.)

DR. CAIN (Presiding): The meeting of the House of Delegates is not adjourned. Dr. Johnson, I am delighted to know the progress Blue Shield has made since two weeks ago.

Gentlemen, we are now sitting down again as the House of Delegates of the South Carolina Medical Association.

The Committee on Medical and Hospital Insurance Contracts, whose report has been published in the Journal, has a supplemental report which is part of a brochure that was given you this morning, entitled "Supplemental Report of Insurance Committee." This mimeographed report, along with the report already published in the Journal, is referred to the Committee on Insurance, Blue Cross and Blue Shield.

DR. HARVEY ATWILL, JR. of Orangeburg (Recognized by the Chair): I would like to ask about this committee's report. At the last House of Delegates' meeting in May last year, we had a resolution presented and passed to the effect that we would make a study of the acquisition of a single report form, physicians' report form on insurance. Am I correct in con-

sidering that this was referred to this particular committee?
THE CHAIR: Yes, sir.
DR. ATWILL: Could you give me some information about what action was taken by the committee? Is the chairman present?
THE CHAIR: The Chairman is present. Have you got any report or any action on that particular phase of it, which was referred to your committee?
DR. LAWRENCE: No, we have no particular report on that particular matter.
THE CHAIR: No report on that particular matter, however I will rule that that is within the province of the reference committee on medical and hospital insurance contracts, if they wish to make a recommendation on that score.
Medical Advisory Committee to Selective Service, Dr. Frank Owens, Chairman. We will have your report now, Dr. Frank Owens.

Advisory Committee to Selective Service

DR. FRANK OWENS:
Report of the Medical Advisory Committee to Selective Service To the S. C. Medical Association.
The Medical Advisory Committee to Selective Service was requested by National Headquarters to act in a standby basis.
The Doctor Draft Law is no longer in effect.
Many doctors are liable under the regular draft act. The Government has adopted a policy of not drafting doctors into service as foot soldiers, but of offering them commissions or of giving them the opportunity of applying for commissions.
Many doctors who would have been called up under the regular draft were deferred to accept intern or residency appointments. It was expected by the armed services that enough of these young doctors would apply for commissions so that no draft call would be necessary. This has not proved to be the case. Therefore the Armed Services have found it necessary to ask Selective Service to issue a call for 250 doctors. If enough doctors request commissions as the result of attention having been called to the need of the Armed Services, then the draft call may be cancelled. The need at present is in the Air Force.
Draft Boards have been ordered to have all young doctors examined not because all of these doctors are to be called but because they want to know how many doctors are physically able.
If the draft call is carried out then the youngest will be called first and presumably non-fathers before fathers.
The regular draft act provides ordinarily for liability up to 26 years of age, however if deferment has been made then the liability extends to 35 years of age.
The present draft call for 250 physicians for the Air Force is for delivery in July, 1961.
Doctors newly graduated are advised to seek a commission in their chosen branch of service.

Frank C. Owens, Chairman
Medical Advisory Committee to
Selective Service

Accident Prevention

We will now have a Committee report on Accident Prevention, Dr. Henry Moore, Chairman. Dr. Moore.
DR. HENRY MOORE, Columbia: Mr. Chairman, members of the Medical Association, I am the Chairman of the infant committee of this august medical association; I think we have all heard a great deal this afternoon about rules and committees and I heard one recently about a new Kennedy piece of legislation that was introduced in Washington I think we all would be a little interested in it, since it doesn't affect us but it affects some of our relatives. It seems that Mr. Kennedy is going to cover all fronts. He has introduced a new piece of legislation allowing our Hebrew brothers to eat pork any day in the week, the Catholics to eat meat on Friday, and the Baptists to drink liquor in front of other Baptists. Now to get down to the more serious side of my report, inasmuch as our committee is an infant committee, nine months of age, we were a little late in getting material enough to make a report in time to get it into our medical journal. However, there was a factor that prevented this in that we had a call, a state-wide committee meeting on March 21-23, to consider one of our most important problems, and also I had a pregnant secretary, who had a boy baby about the same time as this and she didn't come back to work in time to get it in.
Report and Recommendations of the South Carolina Medical Association's Accident Prevention Committee.
I. This committee was first appointed September 2, 1960 on the recommendations of the State Pediatric Society and Dr. Hilla Sheriff of the State Board of Health.
The following members comprise this committee:
Margaret Jenkins, M. D., Charleston
William R. DeLoach, M. D., Greenville
L. W. Blackmon, M. D., Columbia
James B. Berry, Jr., M. D., Marion
O. B. Mayer, M. D., Columbia
Henry Moore, M. D., Columbia, Chairman
II: Two Committee meetings have been held, the original organizational meeting at Charleston, November 19, 1960.
It soon became apparent that a state-wide accident prevention program would entail considerable planning and organizational work to produce any worth while results. To date the committee has not had adequate time to carry out its plans which will of necessity include an educational program for our state Medical Association's local components and individual members. In actuality, very few physicians are adequately acquainted with or cognizant of the tremendous amount of accident prevention work that needs to be done or that needs medical guidance and counsel.
At present Dr. Margaret Jenkins is attempting to organize and plan a panel type of educational program which would include a group of physicians acquainted with accident prevention work. It is hoped that by these efforts, physicians on the local level can be induced to participate in local safety work. At the present time Dr. Jenkins has not completed her program and it is hoped that she will be permitted to go on with this work next year.
The committee further recommends that a speakers' bureau on accident prevention be set up by every organized county medical society. By such action, speakers could be made available to local lay and professional organizations or safety groups in the various communities. This is especially valuable for PTA, Boy Scouts, Highway safety groups, and other organizations that are interested in educating our lay people and children.
Educational pamphlets and safety publications designed to indoctrinate parents in proper accident prevention safe-guards should be urged for all doctors treating children. The committee, in cooperation with the State Board of Health's Accident Prevention program, is developing a safety pamphlet concerned with the prevention and treatment of dog bites. This will be prepared in pamphlet form for use in doctors' offices, health departments and hospital emergency departments.
III. Safety Legislation: Questionnaires concerning eye injuries were mailed out to all physicians doing ophthalmology in the state, and while only approximately 15 replies have been forthcoming to date, the

committee felt that there was sufficient data available to recommend certain action be taken by the legislative committee of the state Medical Association. Inasmuch as eye injuries from lead-type foreign bodies (BB's) are a frequent cause of total loss of vision and eyes in this state, this committee recommends that legislation be enacted to forbid the sale or manufacturing of lead missiles or shots for any type of gun. (I should have said toy gun or something like a pellet gun.) Since lead BB's are not magnetic and cause extensive destruction of the eye structures, it would appear reasonably simple to require that all types of BB's or pellets for sale in air-rifles, pellet guns, etc., be manufactured out of steel or other magnetic metal. Such magnetic foreign bodies can usually be removed from eyes without total loss of vision or eye.

The second legislative recommendation by this committee concerns automobile drivers licensing. This committee recommends that the state Medical Association actively promote or instigate through proper channels, legislation requiring vision acuity tests on all renewal applications for drivers license regardless of age. Vision examinations such as are required on original licensing would be adequate; and if done periodically as licenses are reissued, would certainly reveal many hundreds of unsafe drivers. When good vision is so essential to safe driving, certainly organized medicine should work for such a safety measure.

IV: The second state-wide committee meeting was held in Columbia, March 23, 1961. Only two committee members were present, plus Dr. Hilla Sheriff, State Board of Health, and Dr. Casper Wiggins, Chairman, South Carolina Accident Prevention Committee of the American Academy of Pediatrics. This meeting was called primarily to consider a proposed state-wide study of automobile-produced injuries by the Cornell University Crash Injury Research Unit.

This study proposes to carry out a three year investigation in this state with the program being carried out in the six highway patrol districts in consecutive six month periods. The following organizations are being requested to cooperate in this program: (1) S. C. Hospital Association. (2) S. C. State Board of Health. (3) S. C. Highway Patrol and (4) S. C. Medical Association.

The automotive crash injury research is a fact-finding program which is producing valid information concerning specific causes of injury to occupants of passenger automobiles involved in accidents. It is believed that many injuries, especially in moderate accidents, may be prevented when cars are designed to afford better occupant protection during accidents. In order to design increased protection in automobiles, automotive engineers need to know specifically which features of design and accident factors are most frequently associated with injury cause, such as windshield, instrument panel, steering wheel, roll overs, ejection, etc. Moreover, when design changes are made, it is necessary that their effectiveness in reducing injury be evaluated for further guidance of engineers. A representative of every major automobile manufacturer joined in the planning of this project and periodically receives progress reports and findings based on statistical data. As a result of previous studies since 1956, automobile manufacturers have engineered and tested in their laboratories new safety-designed features such as improved door locks, instrument panels to reduce their injury-producing potential, improved injury-absorbing steering wheels, and seat belts. Automobile manufacturers cannot make practical design changes unless statistical data based upon thousands of cases prove which type of accidents are most frequent and which design features are the causes of injury. Furthermore, as design improvements appear in new models, a large number of cases are needed to evaluate the effectiveness of such changes.

Previously, 19 states have already participated in this study. The Department of the Army, National Institute of Health, and U. S. Public Health Service have furnished funds. In addition, Chrysler Corporation has provided support since 1955, and Ford Motor Company since 1958. The Armed Forces are vitally affected by the high percentage of passenger automobile casualties because their records reveal that a greater number of man-days are lost by military personnel injuries in passenger car accidents than by any other single cause, including combat.

This committee strongly recommends that the S. C. Medical Association approve and actively support this vitally needed study of the Cornell Crash Injury Research Program. Each and every practicing physician should lend full-hearted support and cooperation by filling out requested injury reports. Only accidents occurring outside incorporated cities and towns will be investigated in this program.

Henry W. Moore, Chairman
S. C. Accident Prevention Com.

THE CHAIR: Thank you, Dr. Moore, this report will be referred to the Committee on Miscellaneous Business.

We will now have the report of the State Board of Medical Examiners, Dr. George Wilkinson. (After a pause) Dr. Wilkinson is not present, is there anyone present prepared to make his report? (It was stated from the floor he had just stepped out and someone was sent to call him.)

While we are waiting on Dr. Wilkinson, we will receive the report of the Executive Committee of the State Board of Health which has been published in the Journal. Dr. Wallace, is there any further report? (It was stated there was no supplemental report.)

Is there any old business to come before the meeting?

DR. KENNETH LAWRENCE (Recognized by The Chair) May I introduce this supplemental report? I was new on the insurance committee and I would like to present it to the delegates, if I may. It was turned in initially, but I think it should be presented, do you want me to present it?

THE CHAIR: Dr. Lawrence, was that the one that was presented by mimeographed report?

DR. LAWRENCE: That is correct, but I just want to be sure that everyone was familiar with it.

THE CHAIR: Everyone has read it and I would like for you to take that up with the reference committee this afternoon.

Is there any old business to come before the house?

DR. WILLIAM WESTON, JR. (Recognized by The Chair) Do you wish to hear anything about Civil Defense and what recommendations we have to make? I have been acting Chairman for the last two years. I would like to make a report.

Civil Defense

THE CHAIR: We will hear from the head of Civil Defense of South Carolina, Dr. Weston.

DR. WM. WESTON, JR.: Mr. President, delegates and guests. I made a brief report this morning in Council. Dr. Cain announced that I was head of the Civil Defense. That is a misnomer, Mr. Charles B. Culberson is the director, and a darn good one, of the Civil Defense and I hope you will continue to give your cooperation. I do not think that we are alive and alert to the situation and they have given me where the 16 units are in this state and I recommended, through Mr. Culberson's suggestion, that the County Health Officer be in charge of these and we are now placing it in the hands of a new committee, that is, the responsibility of the hospital units.

This is a resolution that our local society passed and through Dr. Bushouse's activity a great many other

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counties have passed it, and I think the state Medical Association should pass it.

"*Now Therefore Be It Resolved* that the Columbia Medical Society of Richland County does hereby accept the responsibility to organize, train and prepare for Emergency Medical Services in Richland County.

Be It Further Resolved that if a national emergency or natural disaster should occur an Emergency Medical Support Team, composed of such doctors, specialists, nurses, nurses aides, technicians and orderlies as the unit chief decides are required for the formation of an effective medical team, will assume their secondary or alternate role as members of a Medical Mobile Support Team and will, if in the judgment of the State Civil Defense Director such action is necessary, transport the medical team to those areas where their services are urgently needed."

THE CHAIR: Thank you, Dr. Weston. I will refer Dr. Weston's report to the committee on Public and Industrial Health.

Gentlemen, I have one announcement to make. The South Carolina Civil Defense has an exhibit of a mobile operating room, this is a sample of the whole hospital. This room is set up in the public library of Charleston County which is right across the street and it is open today from 5:00 until 7:00 and tomorrow from 1:00 until 3:00 and we certainly hope that you will take this opportunity to go by and see just what part of these field emergency hospitals look like when they are set up.

Now, these committees will meet when this assembly adjourns and will continue in session until their business has been completed and they will report to the House of Delegates tomorrow morning. If any of you needs secretarial help in preparing your report get in touch with Mrs. Motte in the booth and they will have girls down there to help you write your reports. Is there any further business?

If not, I declare this assembly recessed until tomorrow morning.

(HOUSE OF DELEGATES RECESSED)

Minutes
to be continued
in October number

PHILIPS ROXANE

Despite the present pressures on pharmaceutical firms, a new and large company has just announced its debut in the manufacturing field. Philips Roxane has an extensive background here and abroad and operations and affiliations with a number of important firms. Its headquarters will be located in St. Joseph, Missouri, and among its projects is the development of a measles vaccine now in extensive clinical trial. Other endeavors will be in the line of steroid chemistry, and many other lines.

The Columbus Pharmacal Company of Columbus, Ohio, will be the nucleus for marketing in the new organization and will assume the new name. Veterinary products will also be produced by an affiliate, the Anchor Serum Company.

The Company has just produced an interesting non-commercial exhibit at the recent meeting of the AMA.

DR. W. R. DUKE

(Continued from page 400)

University in Atlanta, where he was highest honor graduate. He was an officer in the U. S. Navy for 11 years, leaving the Navy with the rank of commander to do graduate work in surgery at the Mayo Clinic.

Dr. Duke was a fellow of the American College of Surgeons and a member of the American Medical Association, the Southern Medical Association and state and local associations.

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